DOCUMENT RESUME

ED 482 008 CG 032 732

TITLE	Caution: Crisis Ahead. A Crisis Counseling Handbook.
INSTITUTION	California Association for Counseling and Development, Fullerton.
PUB DATE	1996-00-00
NOTE	190p.
AVAILABLE FROM	CACD, 2555 East Chapman Ave, Suite 720, Fullerton, CA 92831. Tel: 714-871-6460; e-mail: cacd@cacd.org; Web site: http://www.cacd.org/.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS
DESCRIPTORS	*Counseling Techniques; *Counselor Training; *Counselors; *Crisis Intervention; Guides; *Resource Materials
IDENTIFIERS	California

ABSTRACT

In 1992 the Professional Development Committee for the California Association for Counseling and Development (CACD) launched a Crisis Intervention Project. This guidebook is the outcome of that project, and it demonstrates the committee's efforts to provide support for and assist counselors and other helping professionals deal with crisis. The materials, methods, and techniques presented in this manual have been gleaned from experienced professionals, printed resources, and special programs. Ideas and concepts are constantly brought to CACD's attention and an attempt has been made to incorporate workable ideas as they emerge. Designed as a user-friendly manual, the reader can add materials and select or adjust those ideas that work best for him or her. Instead of providing the user with just another handbook to read, workshops are provided to give participants hands-on practice and personal interaction. (Author)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 482 008

CAUTION
CRISIS AHEAD

A Crisis Counseling Handbook

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Prepared by

The Professional Development Committee
California Association for Counseling and Development
Fullerton, California

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE, AND IN ELECTRONIC MEDIA FOR ERIC COLLECTION SUBSCRIBERS ONLY, HAS BEEN GRANTED BY

W. STRONG

2A TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Handbook Sponsored by

Variable Annuity Life Insurance Co. (VALIC)
CACD Education Foundation

CG032732

BEST COPY AVAILABLE

CAUTION
CRISIS AHEAD

A Crisis Counseling Handbook

Prepared by

The Professional Development Committee
California Association for Counseling and Development
Fullerton, California

Handbook Sponsored by

Variable Annuity Life Insurance Co. (VALIC)
CACD Education Foundation

BEST COPY AVAILABLE

INTRODUCTION

In 1992, CACD President Dr. Mary Honer, in collaboration with Winifred Strong, Chair of the Professional Development Committee for the ***California Association for Counseling and Development (CACD)***, launched a Crisis Intervention Project. The outcome of this program, **CAUTION: CRISIS AHEAD**, and the Handbook demonstrate the committee's efforts to provide support for and assist counselors and other helping professionals deal with crisis. The materials, methods, and techniques presented in this manual have been gleaned from experienced professionals, printed resources, and special programs. Ideas and concepts are constantly brought to our attention and an attempt has been made to incorporate workable ideas as they emerge. Designed as a *user friendly* manual, the reader can add materials and select or adjust those ideas that work best for him or her. We describe this as a *handbook still in progress*.

Instead of providing the user with just another handbook to read, workshops are provided to give participants **hands-on practice** and **personal interaction**. In the event of a crisis, the counselor will feel confident and more adequately prepared.

ACKNOWLEDGMENTS

Special thanks to Dr. Mary Honer, Dr. Richard Hoover, and members of the CACD Executive Council who saw promise in the idea and gave support to the emerging project. Many thanks to the counselors and other helping professionals who shared information about special programs and activities dealing with crisis intervention. Our gratitude to Warren Sapp, counselor, committee member, and editor, who went beyond the call of professional duty and volunteered hours of personal time and computer expertise during the Summer of 1994.

Our appreciation to VALIC and the CACD Education Foundation who sponsored publication of the handbook; Dr. Melba Coleman, CSU Dominguez Hills; Dr. Joseph Dear, Commission on Teacher Credentialing; the Garden Grove Pupil Personnel Association; Dr. Anita Gray; George Kambertz, counselor at Paramount High School; Marilyn Martin for final editing of the handbook; Mary Schoenfeldt, Schoenfeldt and Associates; our spouses: Jim Hoover, Ted Honer, Mary Sapp, Frank Sesno, and Fred Strong; and ERIC/CASS, University of North Carolina at Greensboro.

Special recognition to the following:
Elizabeth Kubler Ross, author of ***On Death and Dying***
Suni Patterson and Ron Straub, authors of ***School Crisis Survival Guide***
Linda Cunningham, founder of **Teenage Grief**, a training program to facilitate grief support groups for teens
Jessie Freeman and Lillian Duncan, LAUSD, developers of the resource program for elementary age children, **Children Grieve Too**
Southwest Regional Laboratory (SWRL), provider of the checklists found throughout the handbook

Handbook Contributors

Dr. Mary Honer
School Psychologist
Garden Grove Unified School District
Garden Grove, California

Mrs. Carol Hoover
Counselor
Lawndale School District
Lawndale, California

Ms. Connie Messina
Counselor Educator
San Diego State University
San Diego, California

Ms. Rosemary Rubin/Mr. Richard Lieberman
School Counselor/Consultant
Suicide Prevention Unit
Los Angeles Unified School District
Los Angeles, California

Mrs. Winifred Strong
Consultant/Counselor
Laguna Hills, California

Mr. Warren C. Sapp
Counselor
Whittier High School
Whittier. California

Mr. Marcelino Saucedo
Bilingual Counselor
Cerritos College
Norwalk, California

Dr. Alice Healy-Sesno
Consultant-in-Charge
Los Angeles Office of Education
Los Angeles, California

Mr. Larry Steele
Counselor
Alessandro High School
Hemet, California

Dr. Richard Hoover
Executive Vice President
California Association for
Counseling Development
Fullerton, California

Editor: Warren Sapp
Final Editing and Handbook Preparation: Marilyn M. Martin

WRITEWORD Editorial Services
213 Beal Ave., Placentia, CA 92670 (714)528-0258

BEST COPY AVAILABLE

Table of Contents

Stress Busters ix
Introduction to Crisis Intervention 1
Be Prepared 1
Prepare !!! Plan !!! Practice !!! 2
What is a Crisis 5
The Skills of Crisis Counseling Intervention 7
Crisis Events 11
Crisis States 11
Crisis Intervention 14
Psychological First Aid 15
Crisis Intervention Outline 18
Step #1: Establishing Contact 19
Step #2: Assessment 21
Step #3: Examining Solutions 23
Step #4: Devising a Plan of Action 25
Step #5: Follow Up 25
De-escalation 27
Discussion Guide 27
General Questions 28
Sample Crisis Situations 28
Crisis #1 28
Possible Discussion Questions Following an Incident Involving Racial Conflict 29
Crisis #2 29
Guidelines for Closure 30
Introduction to Crisis Intervention: Other Resources 32
Triage Assessment Form: Crisis Intervention 33
Triage Assessment Form: Crisis Intervention 34
Triage Assessment Form: Crisis Intervention 35
Do's & Don'ts of Psychological First Aid 36
Crisis Symptoms and Treatment Strategies 37
Crisis Management Planning Checklist 39
General Crisis Intervention Checklist 40
Checklist for Long-Term Follow-up 41
Long-term Follow-up to Crisis Situations 42
Off-Track/Summer Crisis Intervention checklist 43

Youth Suicide 44
Background 45
Societal Stressors 46
Risk Factors 47
Warning Signs 48
Crisis Intervention and Suicide 49
Confidentiality 49
Collaboration 49
General Actions 49
The Intervention Process 50
Step #1: Assessment of Risk 50
Step #2: Warn the Parents 51
Step #3: Provide Community Referral Resources 51
Step #4: Follow-up and Support Family 52
If High-Risk 52
If Minimal or Moderate Risk 53
Documentation 53
For the Returning Student 53
In the Aftermath of Suicide 54
Identifying Students at Risk 55
Clusters 56
Contagion 57
Glorification 57
Media 58
Youth Suicide: Other Resources 59
Bibliography 60
Stress and Adolescence 60
Suicide: Interpretation, Prevention, and Intervention 61
Suicide Attempt Checklist 64
Suicide Risk Checklist 65

Social Unrest 66
Introduction 67
Proactive Measures for Social Unrest 68
Responding to Non-Violent Social Unrest 68
Responding to Violent Social Unrest 69
Reducing Tension 70
After Order is Restored 71
The Rumor Mill 72

Social Unrest: Other Resources 73
Active Listening Techniques 74
Saying it Differently 75
The Conflict Mediation Process 76
Agreements 77
"I" Message 78
Conflict Manager Report Form 79
Mediation Procedure 80
Mediation Process 81
Mediation Contract 82
Riot Checklist 83

Physical and Sexual Abuse Counseling 84
What Does the Counselor Do? 85
Personality Disorders 86
Histrionic Personality Disorder 86
Borderline Personality Disorder 86
Avoidant Personality Disorder 86
Dependent Personality Disorder 87
Dysthymia 87
Post-traumatic Stress Disorder 87
References 90
Date Rape 91
Myths About Date Rape 91
Aftereffects of Date Rape 92
Recommended Program for Campuses 92
Rape Response Checklist 94
Domestic Violence 95
Some Causes of Domestic Violence 96
Common Similarities 96
Why does It Happen 96
Types of Abuse 97
Domestic Violence Statistics 98
Warning Signs of Abuse 99
The Abusive Parent 99
The Abused Woman 99
The Abusive Man 100
Battering 100
The Cycle of Violence 101
Cycle of Violence – Three Phases 101
Violence Cycle 103
Power and Control 104

Common Characteristics of a Male Batterer 105
Common Characteristics of the Female Victim 106
Myths About Battered Women 107
Why Does the Battered Woman Stay? 108
Legal Procedures for Abused Women 109
Bibliography 110

Natural & Physical Disasters 111
Natural Disasters 112
Assessment 113
Post-traumatic Stress Disorder 114
Resources 117
Bibliography 118
Natural & Physical Disasters: Other Resources 119
Helping Children After a Disaster 120
When Do Reactions Occur 120
Early Childhood: Ages 5 to 11 120
Preadolescent: Ages 11 to 14 122
Adolescent: Ages 14-18 123
Natural Disaster Checklist 125

Personal Loss: Bereavement and Grief 127
Personal Loss 127
Symptomatic Behaviors Common to Bereavement & Grief 128
Shock 128
Panic 128
Denial 129
Depression 129
Anger 129
Bargaining 129
Guilt 129
Acceptance 129
Hope 129
Counseling Persons Experiencing Loss or Grief 130
What to Expect in Normal Grief 132
Bereavement and Grief: Other Resources 133
What Counselors Need to Know for Children Coping With Grief 134
Intervention Strategies and Activities 135
Grief and the Adolescent 136
Grief Support Group Sessions 137
Session I 137
Colors of Grief 139
Session II 140

Session III 141
My Story About What Happened 142
Session IV 143
Myths About Grief 144
Session V 145
You Can Help a Grieving Person 146
Session VI 147
Session VII 148
Session VIII 149
Grief Support Group Evaluation 150
Annotated Bibliography 151
Guidelines for Responding to a Student's Death 158
Open-ended Questions for Classroom Discussion ... 159

Homicide and Violence 160
Introduction 161
Emergency Response:
Crisis Management Activities 162
Student Worksheet 165
Anticipated Responses to Crisis 167
Grief and Resolving Loss 168
The Support System 168
Prevention and Intervention 169
Guidelines for Counselor Role 171
Resources 172
Homicide Checklist 173
Additional Resources 174
Guidelines to Develop a Counselor Resource File ... 175
Selected Resources: Crisis/Loss 176
Sexual Orientation 178
Multicultural 179

Stress Busters

I. Take a few moments . . .

When the stress of life seems too much . . .
Listen to the dreams in your heart
and recall the memories you cherish most.

Take time for whatever gives you strength
to face each challenge . . .
Time for whatever touches your life
and means the most to you .

Take time to treasure
each precious moment
And enjoy life! !

From: Sangamon . . "Blessings of the Heart"

II. Stress reduction exercise

Use a few minutes for the following:

A. Place your index and middle finger tips at the temple.
Press lightly against the temples, and massage in small circles

B. Take two or three deep breaths. Breathe in through the mouth and *slowly* exhale through the nose.

C. If you are in public, give a brief warning and regrets to friends and neighbors . . .
Then take a deep breath and blast out with a roaring yell ! ! !

D. Lean back, close your eyes, and listen to some of your favorite music.

If the stress remains, start again and repeat from A.

III. Seek a comfortable colleague or support group

A. Describe your concerns.

The prime duty of the Support Person
is to
"Listen to understand – Not to fix . . ."
Bill Kell
Counseling Psychologist (1917-73)

Introduction to Crisis Intervention

Be Prepared

EARTHQUAKE HITS SOUTHLAND

STUDENT KILLED ON CAMPUS

FIRESTORM SWEEPS COMMUNITY

YOUTH COMMITS SUICIDE

CHILD SHOT IN DRIVE-BY SHOOTING

FLOOD DAMAGE WIDESPREAD

FAMILY KILLED IN AUTO ACCIDENT

KILLER HURRICANE STRIKES COAST

PLAYMATE SHOOTS FRIEND

TORNADO TERRORIZES TOWN

These are all headlines and breaking stories on television. They are *news bits* that occur so frequently newspaper readers and TV viewers seem to have become desensitized to the real meaning . . . until it happens to someone they know.

If a tragedy or traumatic event struck your campus or community, would you know what to do? What would you do first? How do you recognize that a person is in a crisis? It is the purpose of this handbook to help counselors answer these questions as well as others.

"Be Prepared" is the well-known motto of the scouting programs. As counselors, *we* need to *be prepared* to intervene when we are confronted with a crisis situation. It seems paradoxical, but the best way to intervene in a crisis is to prepare, plan, and practice.

Prepare !!! Plan !!! Practice !!!

How can you prepare for a crisis? How can you plan for a crisis? How can you practice for a crisis?

The *spontaneous* remarks and humor of successful stand-up comedians such as Bob Hope, Carol Burnett, Robin Williams, and Jerry Seinfeld were honed by hours and hours of preparation. Football players, basketball players, and other athletes practice plays over and over during the week, so that they will be able to respond to the unexpected in a game. As counseling professionals, our success in helping others is based upon extended preparation (i.e. training and practice).

You will discover from participating in this workshop that you possess many of the necessary skills important in crisis intervention. However, to be an effective crisis intervention counselor, further preparation, planning, and practice are critical.

If your organization already has a plan, the next step is to regularly **Practice and Debrief Your Plan.** Work with your organization to develop a

simulation, or *dry run,* and practice it like schools practice fire drills. Then debrief by discussing what happened and problems that have occurred during the simulation or possibly could occur. After the debriefing, refine your organization's crisis plan.

Anecdote

A counselor was involved in an emergency situation during an earthquake that struck just before the start of the school day. Most of the students were on the way to school, and while that quake was not as strong as the Loma Prieta or Northridge earthquakes, both students and staff members were unsure what to do when they arrived at school. Fortunately the school had practiced an all-school earthquake disaster drill a year earlier; and while the plan was not polished, it did provide the staff with a course of action.

Taking action in a calm, coordinated manner provides support during a crisis situation. The establishment and practice of a plan provided confidence and support to those involved in the crisis situation.

Please remember that *once is not enough* because frequently there is a change in staff, students, or clients, and it is important to practice your plan at regular intervals in order to be prepared.

To be prepared for an emergency or crisis situation, you need to have a **Personal Plan** as well. When a natural or physical disaster occurs, its effects are usually widespread in a community, and often separate or isolate people from their families. In some cases, it also prevents communication with them.

In most situations, CAD members are expected by their employers to help with the crisis situation until students or clients have been adequately cared for, especially if a disaster occurs while a member is at work. Consequently, it is important for you to discuss and develop a plan with your family prior to a disaster, so that they and you know what to do if a disaster occurs while you are at work and your children are at school.

What is a Crisis?

Crisis. . .what is it? Be prepared to know what is a crisis. What makes a crisis – a crisis? A crisis can be:

- "an emotionally significant event or radical change of status in a person's life"
- "an unstable or crucial time or state of affairs whose outcome will make a decisive difference for better or worse"
- "the decisive moment (as in a literary plot)"
- "a turning point for better or worse in an acute disease or fever"

> Webster's New Collegiate Dictionary defines a crisis as, "*a time of danger and opportunity.*"

Karl Slaikeu, author of ***Crisis Intervention: A Handbook for Practice and Research,*** researched the Chinese term, or character (weiji), that signifies crisis. He found the Chinese weiji was composed of two characters: one signified danger and the other signified opportunity.

He also found the English word, crisis, was derived from the Greek term, krinein, which means to decide. Derivations of the Greek word indicate that a crisis is a time of decision and judgment or a turning point during which there will be a change for better or worse.

Each of these definitions contains the idea that a crisis is a significant event that may be a turning point in a person's life for better or for worse.

Why does an event totally disrupt one life but has no apparent effect on another person; why does

BEST COPY AVAILABLE

one person suffer from the results of a crisis event more severely than another. One author (Nowak, 1978) suggests that whether or not the impact of a particular event triggers a crisis state in a person depends upon that event's timing, intensity, duration, sequencing, and the degree of interference with other developmental events. Other factors that may contribute to an event's becoming a crisis to a person depend upon: 1) personal resources: temperament or experience; and 2) social resources: community or family support.

An event that causes the onset of a crisis state in a person's life may be sudden – a natural disaster, such as an earthquake; it may be traumatic – a violent act, such as rape or a homicide; or it may be subtle – one's 30th or 50th birthday.

Some events are so universally devastating they precipitate a crisis state; for example, the sudden death of a loved one or rape. Other life events, however, may or may not induce a crisis state and must be viewed in the context of the individual's total development. These include birthdays, the birth of a child, and retirement (Slaikeu, 1984).

Anecdote

One of the committee members indicated that he had two acquaintances who happened to be ministers and whose wives each had an unplanned birth of a baby in their early forties after their other children had become teenagers. The birth of an unplanned baby precipitated a crisis state, a depressive episode, in one woman who viewed the birth as restricting her life. The other woman viewed the birth of her unplanned baby as a "gift from God" and the birth did not precipitate a crisis state in her life.

The Skills of Crisis Counseling Intervention

Most CACD members have had training and have expertise in the basic counseling skills, especially those skills originally outlined by Carl Rogers – the skills of **empathy, genuineness,** and **acceptance.** These skills are especially important in dealing with a person who has experienced a crisis.

Empathy is that repertoire of skills that enables the crisis counselor to sense and understand the inner feelings and ideas of the person in crisis as well as the ability to communicate to him or her this understanding in a meaningful manner.

Genuineness is the group of interpersonal skills that allows a crisis counselor to be open in such a way there are no facades or professional fronts.

Acceptance is an attitude on the part of the crisis counselor that accepts and cares for the person in crisis for who he or she is – whether or not that person *deserves* it or reciprocates the feelings.

An important part of communicating empathy is the skill of attending according to Gilliand and James in ***Crisis Intervention Strategies.*** **Attending** is the ability to stay focused on the nonverbal responses such as facial expression and body posture of the person in crisis as well as the tone, diction, pitch, modulation, and use of language in their verbal responses. It is the ability to put the counselor's own concerns on hold and focus intently on the other person's presence and situation. Being able to convey this skill to persons in crisis takes concentration, effort, and practice.

The ability to verbally communicate empathetic understanding is found in the skills of **responding, restatement,** and **reflection.** These skills involve focusing the crisis counselor's attention on the other person's affective and cognitive messages.

By using the skill of attending, the crisis counselor is able to focus on the person in crisis and

identify that person's *core* feelings and concerns and then communicate this understanding in words and feelings that are meaningful to the person in crisis.

Through the effective use of these responding skills, the crisis counselor is able to assist the person in crisis to gain a clearer view of his or her own feelings, motives, and choices.

The counselor is then able to help the individual begin to develop a better understanding of the full impact of the crisis by the skills of **refocusing** and **reframing.** These skills assist the person in crisis, who is usually stuck in viewing the crisis from his or her own internal frame of reference and emotional bias, to reconstruct a crisis event from a broader and usually more rational perspective.

Most of these skills were developed from a *client centered, or nondirective,* counseling framework and are useful in working with individuals who have some ability to respond on their own. However, during a crisis, some people become immobilized and cannot respond, so a more directive approach is necessary.

Anecdote

As indicated previously, a counselor was involved in an earthquake. During the evacuation after the first quake, a staff member experienced severe shock, became immobilized and was not evacuating. This necessitated the counselor to gently, firmly, and physically guide the staff member out of the building and into safety away from the buildings.

Directive counseling is needed when the person in crisis becomes immobilized and cannot physically or rationally respond, or is a danger to themselves or others. When the use of directive counseling strategies become necessary, the crisis counselor takes temporary control, authority, and responsibility for the situation.

Directive methods are necessary when the person in crisis becomes immobilized:

- Due to health problems, chemical use, psychotic episode, or organic dysfunction and needs immediate hospitalization.
- Due to severe depression.
- Due to severe shock, bereavement, or loss.
- Due to a high state of anxiety that prevents functioning until the anxiety subsides.
- Due to being out of touch with reality.
- When a person becomes a threat to himself or herself or a danger to others.

Anecdote

A counselor was involved, along with the school psychologist, administrators, and other staff members, in restraining a young female student who was emotionally out of control. She was later diagnosed as being under the influence of an illegal substance. It took four or five adults to restrain her in a manner that prevented her from hurting herself.

In these situations, the crisis counselor frequently needs to consult with others as well as involve community agencies. The crisis counselor should always consult with others when in doubt about the safety of the person in crisis.

While a crisis intervention counselor needs to be directive at times, his or her goal should be moving toward a **collaborative counseling** relationship rather than a directive or nondirective counseling relationship.

Using those skills developed by the client-centered school of counseling, the crisis counselor moves to a collaborative mode as an action plan is developed for the person in crisis. The crisis counselor in a collaborative mode with the person being

counseled begins to examine, analyze, and list alternatives available to that person.

The **plan of action** is an important component in crisis counseling because it is the instrument that is used to assist the person in crisis in getting through the current situation by reconstructing and further developing their internal coping mechanisms and making the transition to long-term coping.

The plan of action that is collaboratively developed should:

1. Incorporate the individual's internal coping strategies.
2. Utilize resources in the individual's support system and community.
3. Identify concrete, positive, and constructive action the person is capable of implementing.
4. Not overlook the immediate needs of the individual, such as food, housing, safety, etc.

Another important skill in being a crisis counselor is the **ability to network with community referral sources.** The crisis intervention workers needs to get out into the community and personally know those who provide the services that are important for people who may be in a crisis.

Crisis Events

Crisis Events: *Those situations that precipitate the onset of a crisis state in individuals.*

Life events or situations that may precipitate the onset of a crisis state in an individual include:

- **Developmental Stages**, such as adolescence, high school or college graduation, or retirement
- **Suicide** of a relative, friend, acquaintance, or idol
- **Sexual Assault**, such as rape or sexual abuse of a child
- **Personal Loss** . . . through death such as a death of a spouse, child, friend, school mate, teacher, pet, idol or celebrity, . . .of property, job, money, or significant possessions
- **Violence and Homicide** include being a battered woman, being held as a hostage, drive-by shootings, and armed robbery
- **Social Unrest,** such as riots and terrorism
- **Changing Relationships,** such as marriage, divorce, birth of a baby, leaving home, breaking up, the *empty nest*, and unemployment
- **Natural and Physical Disasters,** such as an earthquake, hurricane, flood, fire, airplane crash, car accident, or explosion

Crisis States

Crisis events present situations to individuals that are dangerous and may pose a threat to their physical or psychological safety as well as an

BEST COPY AVAILABLE

opportunity to successfully resolve the situation. It is the individual's subjective response to the crisis event that determines whether nor not that event precipitates a crisis state.

> **Crisis State:** *A situation in which the normal coping mechanisms and problem solving strategies have broken down.*

For the purposes of this handbook and the training workshop, a crisis state refers to a situation when the normal coping mechanisms and problem solving strategies a person uses for handling the vicissitudes of life have broken down and are no longer successful. This interference in the normal coping processes does not make a person mentally ill, although he or she may exhibit behaviors sometimes associated with mental illness: emotional mood swings, outbursts, immobilization, disorganization, somatic complaints, or inappropriate behavior.

This disruption of the normal responses for dealing with life problems (e.g., talking with a friend, redefining a problem, breaking the problem into manageable pieces, ignoring it, or withdrawing) may be acute and temporary, ranging from only a few hours to a few days or a week, or it may be chronic and prolonged, lasting a few weeks to a few months. In some cases, the crisis state extends and develops into a behavior disorder, and the symptoms of a Post Traumatic Stress Disorder become evident.

In his book, ***CRISIS INTERVENTION: A Handbook for Practice and Research,*** Karl Slaikeu reviewed the crisis counseling literature and found several authors who identified the symptoms of a person in a crisis.

BEST COPY AVAILABLE

The symptoms include:

- emotional reactions such as:
  - crying
  - anger
  - remorse
- feelings such as:
  - helplessness
  - inadequacy
  - confusion
  - anxiety
- physical complaints such as:
  - feelings of tiredness and exhaustion
  - ulcers
  - stomach cramps
- behavior problems such as:
  - interpersonal and family conflicts
  - inability to sleep
  - disorganization
  - interference with work activities

The above behaviors are cues that a person is experiencing stress. Whether that person is experiencing a crisis state needs to be determined by an assessment. Special attention during the assessment is given to three areas: **cognition, affect**, and **behavior**.

Cognition, or the **cognitive state,** of an individual refers to that person's ideas and thinking patterns.

- Is the individual realistic and consistent in their thinking?
- Does the person seem to be rationalizing, exaggerating, or believing partial truths that exacerbate the crisis?

It is important for the counselor to determine what the event means to the person in crisis and what unfinished personal issues have been brought out by the crisis event.

Affect, or the **affective state**, refers to the emotional tone exhibited by the person in a crisis state.

- Is the person agitated or relaxed, angry or hostile, sad and depressed, or euphoric?
- Are the emotional responses appropriate for the crisis?

In assessing behavior, the counselor is looking for signs of immobilization or inability to perform regular functions.

- Is the coping behavior appropriate for the crisis event?
- Is the person's daily functioning impaired? (i.e., eating, sleeping, relations with others, work behaviors)
- Is the person's behavior erratic or unpredictable?
- Is the person's behavior harmful to himself, herself, or others?

The initial focus of the crisis intervention counselor and the paramount concern at all times is the safety of the individual. If the counselor is in doubt or is uneasy about the safety of the individual or others, he or she should consult with other counselors or community service agencies.

Please turn to **Introduction to Crisis Intervention: Other Resources** following this section for a formal assessment tool and some assessment guides for children, teens, and adults.

Crisis Intervention

Crisis events expose individuals to dangerous situations that can be physically or psychologically threatening and trigger crisis states in which the person's normal problem-solving or coping skills are impaired. It is important for the crisis intervention counselor to possess basic counseling skills and keep a

focus on the individual's safety throughout the intervention process.

While members of CACD have received counseling training and are proficient in a variety of counseling skills that are useful in crisis intervention, the goals of crisis intervention differ from those of regular counseling situations.

In crisis intervention, there is a need for the counselor to be more focused, more actively engaged, and more directive when intervening in a crisis situation than when interviewing in normal counseling situations. For this reason, it is important for counselors performing crisis intervention to understand the difference between counseling and administering *psychological first aid,* or crisis counseling.

Psychological First Aid

In 1984, Slaikeu used the term, ***psychological first aid,*** to refer to those services administered to individuals who are experiencing a crisis state. A person in a crisis state is not necessarily *mentally ill* but is experiencing a situation of *overload* in which the crisis has disabled or incapacitated the individual in such a way that normal coping or problem-solving skills do not bring comfort, relief, or adequate solutions, and the person is not able to successfully resolve the situation.

Individuals in a crisis state need psychological first aid, which provides support, focuses on the person's safety, and provides a link to resources. Professor Slaikeu identifies the five components of psychological first aid that are listed on the next page and described in more detail in the sheet entitled, **Psychological First Aid,** found in the resource section.

The five components are:

1. Making psychological contact
2. Exploring dimensions of the problem
3. Examining possible solutions
4. Assisting in taking concrete actions
5. Follow up

Step 1: Defining the Problem The primary goal in this step is to define and understand the problem from the point of view of the person who is experiencing a crisis. The *core listening skills of* **empathy, genuineness, and acceptance, or positive regard,** are the cornerstone for this step. If we are unable to perceive the crisis situation from the other person's perspective, then our interventions will not be effective.

Step 2: Ensuring the Person's Safety Ensuring the person's safety, like assessment, is not a step or stage but is rather a primary focus to be continually considered throughout the intervention procedure or session. Safety refers to the consideration of the physical and psychological danger a person may pose to himself or herself as well as others.

Step 3: Providing Support The crisis counselor takes an active part in intervening in the crisis by assisting the person in crisis in identifying those choices which are most realistic for that situation. The crisis counselor assists the person in identifying *situation supports* (those persons in the present or past who may care what happens to the person and who may assist in this crisis). The counselor also assists the person in identifying those *coping mechanisms* that may have been used successfully in the past and now may be useful again in the current crisis. The counselor then assists the person in crisis

in identifying *positive and constructive thinking patterns*, which may substantially alter that person's view of the problem and lessen the level of stress and anxiety being experienced.

Step 5: Making Plans Using the data developed in the first four steps, the crisis counselor develops a plan that flows logically and directly from Step 4. A good plan should: 1) identify additional persons, groups, or referral resources that can be contacted for immediate support; and 2) provide coping mechanisms – something concrete the person can do now. The step should also include definite action steps the person can comprehend and make his or her own. It is important for this step to be done in collaboration with the person to help them gain a sense of ownership of the plan, so that they may gain control and autonomy in their lives.

Step 6: Obtaining Commitment If the crisis counselor has been listening accurately, collaborating with the person in crisis, then commitment flows from Step 5 and may be nothing more than having the person verbally summarize the plan. The counselor is careful to obtain an honest, direct, and appropriate commitment before the completion of the session.

The goal of the crisis intervention counselor is to assist a person experiencing crisis to develop a short-term plan to deal with the current crisis and make a transition to long-term coping.

Burl E. Gilliland and Richard K. James in their book, ***Crisis Intervention Strategies***, identify six steps for the crisis intervention process:

1. Defining the problem
2. Ensuring the person's safety
3. Providing support
4. Examining alternatives
5. Making plans
6. Obtaining commitment

Using these two models as a foundation, a crisis intervention process and guide has been developed for use with the ***Caution: Crisis Ahead Handbook and Workshop***. It is hoped that this outline will serve as a useful guide and strategy for a crisis counselor whenever an intervention is initiated.

Crisis Intervention Outline

Step # 1 Establishing Contact
Step # 2 Assessment
Step # 3 Examining Solutions
Step # 4 Action Plan
Step # 5 Follow Up

As the authors, Gilliland and James (1993), point out, it is important to keep in mind that:

> *"All people and all crises are similar in that there are global elements to specific crisis types. The dynamics of bereavement"* (as well as other crisis events – Ed.) *"are generic and provide us with general guidelines for intervention. However, treating individual cases . . .is anything but generic.*
>
> *. . . ."An eclectic approach does not mean taking a therapeutic shotgun and aimlessly blasting away at the crisis. . .*

Rather, it means being well versed in a number of approaches . . .and being able to assess the client's needs so that appropriate techniques can be planned and fitted to them." p. 22-23

Step #1
Establishing Contact

Establishing contact, developing rapport, making psychological contact, and developing an understanding of the perspective of the individual in a crisis state is the first step in crisis intervention. Equally important in this first phase is the process of assessing the individual's mental status and determining whether they are a danger to themselves or others.

Open-Ended Questions are the most effective method of initiating contact. They are much more effective than questions that require only a yes, no, or other one-word answer. Some examples are:

"Please tell me what happened?

"What would you like to talk about it?"

"What has been bothering you lately?"

"How does (did) this event affect you?"

"What kind of feelings do (did) you have about this?"

"What ideas or thoughts 'popped' into your mind?"

"What do you think?"

"What do you think you should do now?"

"How will that help you?"

"I want you to describe what that means to you."

"Hi. I'm . . . . . and I am here to listen and talk with some of you who saw the incident this morning."

"Where were you when it happened?"

"What did you see?" or "What happened?"

"What types of feelings did you have when you saw it . . . or heard about it?"

What bothered you the most about it"

Hello, I'm . . . . a counselor and your mother (teacher, sister, friend) told me you've been having trouble eating and sleeping for the past few days.

"What do you think is causing this to happen?"

"Hello I'm . . . . . I am a (counselor, school counselor, high school counselor) and I wanted to take a moment and talk with the class about what happened last Friday night. Most of you probably have heard about the accident; but in case you haven't, Richard was killed in an automobile accident (drive-by shooting, etc.). It is often difficult when a friend or acquaintances dies, especially if they are young.

People grieve in a lot of different ways. Some people cry; some people talk about it; some people don't talk much but just think about it; some people joke or laugh about it and appear to others not to be grieving; some people don't notice a reaction until a few hours or days later; and some people have ideas and feelings that are unusual for them.

Talking about it is one of the best ways to work through the grieving process, and I am here to talk and listen as well as to let you know that you can come by the guidance office to see me or one of the other counselors today or in the next few days or weeks. Right now, I would like to take some time to talk about some of the questions, feelings, and ideas you may be experiencing.

"What are your questions about this?"

"Where were you when your first heard about it?"

"How did it make you feel?"

"What do you remember about Richard?"

"If you had a chance to tell Richard something on the telephone or in a letter, what would you tell him?

"As individuals, what are some ways we can express our grief and appreciation for Richard?

Step #2
Assessment

Assessment is presented as Step #2, but in reality it permeates the entire crisis intervention process from the initial contact to termination after one or several sessions. The crisis intervention counselor's major goal is ensuring the safety of the individual in crisis as well as the safety of others. Consequently, the counselor is doing a preliminary mental status assessment from the very first contact by continually listening for clues to the person's state and answers for the following questions:

- What is the crisis and how severe is it for that person?
- What is the individual's emotional status?
- What resources and support systems are available for that person?
- How dangerous is the person to himself, herself, or others?

If at any time there is any doubt about the safety of the individual or the safety of others, do not hesitate to consult with other professionals and take

action by contacting a spouse, parents, mental health officials, police, or other community agencies. When dealing with large groups of people, such as in a natural disaster or in an institution like a school, it is important to establish a triage station where a preliminary assessment can be made so that the available resources can be effectively utilized and the safety issues may be handled as well.

Assessment of an individual's mental status focuses on that person's affective state (feeling or emotional status), cognitive state (thinking patterns), and behavior. Assessment of these three areas was discussed earlier in this section, and three assessment resources are provided at the end of this section in **Introduction to Crisis Intervention: Other Resources**. These resources include an in-depth triage assessment tool as well as a Crisis Intervention Guide.

The person's mental status can assist the counselor in determining the emotional stability of the person experiencing a crisis state. The duration of the crisis is important in determining the emotional stability of the person as well. It is important for the counselor to discern whether the individual is experiencing an acute crisis state or a chronic crisis state with a crisis-oriented life history.

A crisis state that has a short duration and is relatively recent is usually referred to as being acute, while a recurring long-term crisis state is usually referred to as being chronic. Individuals experiencing an acute crisis state respond well to crisis intervention counseling, while persons experiencing a chronic crisis state frequently need referrals for long-term professional help.

In an assessment, the counselor also needs to be able to identify what Gilliland and James (1993) refer to as the *emotional stamina*, or the ability a person has to handle this crisis situation, and arrive at some solutions. Is the individual capable of working with

the counselor and following through, or is the person so incapacitated that hospitalization may be necessary. Once again, the use of open-ended questions is a very effective means the counselor can use to ascertain the individual's emotional stamina.

Because of the debilitating effect of a crisis, the counselor should always be aware of and pay close attention to the potential for suicide while making an assessment. Suicide and the important issues regarding intervention in this area are covered in more detail in a later section of the handbook.

Step # 3
Examining Solutions

The counselor's approach in crisis intervention is important, but it is especially important in Step #3, **Examining Solutions** because attempts are made to define the problem and examine possible solutions. The counselor's approach may be one of three modes, depending upon the functioning level of the person in a crisis state.

If the counselor determines through assessment that the person is able to initiate and follow through on an action plan pretty much on their own, then the counselor may maintain a ***nondirective counseling*** approach. Through the use of this approach, the counselor assists the person in crisis to use their own strengths and search *within himself or herself* for the capacity, ability, and problem-solving skills to deal with the crisis at hand.

This counseling approach is the one with which many counselors are most familiar and readily use; however, it is not the most effective one for crisis intervention if the individual is not able to follow through on their own.

If assessment reveals the individual in crisis is incapacitated, immobile, or unable to deal with the

current crisis, then a crisis intervention counselor needs to utilize a ***directive counseling*** approach. In this situation, the counselor temporarily takes charge by making decisions and taking responsibility for the situation. Gilliland and James (1993) identify the individuals in a crisis state for whom a more directive crisis counseling intervention approach is most appropriate. They are people:

- Who need immediate hospitalization due to chemical use or organic dysfunction
- Who are experiencing a severe psychotic episode
- Who are suffering from severe shock, bereavement, or loss
- Whose anxiety level is so high they cannot function until the anxiety subsides
- Who, for any reason, are out of touch with reality
- Who are currently a danger to themselves or others

People in crisis often have complex, multiple problems, and it is necessary for the crisis intervention counselor to define the problem and focus on the central issues in order to be able to build an action plan that will assist the individual toward the road of self-sufficiency. In this stage, the problem is defined from the perspective of the individual in crisis, and alternative solutions or actions are collaboratively developed that are grounded in the person's experiences.

Efforts are best spent in assisting the person to identify previous problem-solving efforts or coping skills that worked. The counselor should add any to the list that may have been overlooked by the person. For some helpful hints on the 'Do's and Don'ts of providing crisis intervention, please consult the resource sheet, ***Do's & Don'ts of Psychological First Aid*** by Karl A. Slaikeu, which is found with the other resources for this section.

Step # 4
Devising a Plan of Action

Utilizing one of the counseling approaches described previously that addresses the unique needs of the person in crisis, the counselor works with the individual to establish a plan of action. This plan of action focuses on those strengths and previously successful coping strategies of the individual that were identified in the intervention session.

After exploring all of the alternate solutions, the crisis counselor assists the individual in selecting some concrete positive action that the person *owns* and can implement to begin to regain the ability to function independently. This plan should be sensitive to the individual's cultural background, emotional needs, and the need to achieve autonomy as soon as it is possible. Whenever necessary, the counselor should also use community resources as well.

Step # 5
Follow Up

The crisis intervention counselor needs to follow up with the person after the initial crisis intervention. Slaikeu (1984) indicates that *psychological first aid* is not complete until follow-up procedures or a *contract for recontact* has been agreed upon.

This follow-up is necessary to see if the goals of the intervention have been achieved, support has been provided, lethality reduced, and connection to community resources have been made. In short, is the person *over the hump* and moving out of the state of crisis into a more functional and autonomous status where the counselor can responsibly terminate the intervention process?

If the person is still in a crisis state and part or all of the plan was not implemented, then the counselor needs to go back to Step #2 because crisis intervention has not been completed.

De-escalation

Some crises, such as a natural disaster, civil unrest, or the suicide or murder of one within the group, affect an entire organization, community, or student body. It is very difficult for the group members to return to business as usual due to their fears, hurt, or anger associated with the event. The following discussion guide was designed to assist a teacher, manager, or group leader in addressing the needs and concerns of their organization's members.

There are many approaches used for de-escalation discussions; however no matter which format is used, the objectives remain the same.

- To inform members of the true facts
- To diffuse anger, fear, hurt, embarrassment, or other high emotions precipitated by the crisis by providing a structure within which the members can express their views and emotions.
- To identify and further assist those most traumatized.

Discussion Guide

While some counselors prefer to let the group establish the rules for discussion, others state a few rules and then ask the group to agree to abide by them. However, if the counselor follows the latter procedure, he or she should be sure to explain the rules, allow group discussion, and have the group's consensus.

Some ground rules that are generally accepted follow:

General Questions

1. We want to have a discussion that is both responsible and respectful, so each person will be allowed to speak without interruption.
2. Each opinion will be received without rude comments, noises, looks of disgust, or judgments.
3. Each person must use "I" statements ("I feel . . .;" "I think . . .;" "I believe . . .;" "I disagree . . .;" "In my opinion . . .").
4. Each person must avoid using "You" statements ("You should . . .;" "You shouldn't . . .;" "You're wrong . . .").

Sample Crisis Situations

Explain honestly and simply what has occurred. Give only accurate and pertinent details such as:

Crisis #1

"Yesterday, two students were involved in a fight during lunch. Other students who were there tried to turn it into a racial conflict – which it was not. After school, some students hung around trying to start a fight. Some told their older brothers and sisters there was a race riot at lunch, and some of these older ones were then involved in bullying or attacking other students after school. Today, parents, students, and teachers are concerned about angry feelings, broken friendships, fears and safety."

Possible Discussion Questions Following an Incident Involving Racial Conflict:

1. How do you feel when you hear about a racial conflict? Assist the students, if necessary, to assign terms to their feelings, using words such as angry, afraid, helpless, hurt, etc.
2. Does anyone else feel the same way?
3. How do you feel when you hear that people want to start a racial conflict?
4. What can happen when there is racial conflict in a school or neighborhood?
5. How can a racial conflict in your school affect your friendships?
6. How can racial peace benefit your school or neighborhood?
7. What can each person do to discourage conflicts and violence?
8. What can each person do to guarantee that all people are respected?
9. If you hear or see a friend acting in a racist way, what can you say or do?
10. How can the conflict mediators or teachers help with the problem?
11. What ideas do you have for dealing in a non-violent way with those who are racist?

Crisis #2

Explain honestly and simply what has occurred. Give only accurate and pertinent details. State a few rules for discussion, and ask all to agree by the rules. Look to each person for some sign of agreement by consensus.

> *Yesterday, our community experienced a 7.0 earthquake. There are reports of major damage, deaths, and missing persons. All of us have been touched by this disaster in some way and are experiencing some losses.*

The following are questions that may be appropriate to use in the discussion.

1. Where were you when the earthquake hit?
2. What were you thinking and feeling when it happened? As they reply, assist the students to identify their feelings – frightened, helpless, alone, etc.
3. Did anyone else feel the same way? Emphasize that these are normal responses.
4. Do you have family and friends you are worried about because you have not heard from them yet?
5. What losses are you experiencing because of this quake? Do you feel a loss of security, control, order, or community stability, etc.? Did you lose a friend or family member? Possessions?
6. How can we cope with these losses?
7. Have you noticed or heard about anything good resulting from this disaster?
8. What can we do to help each other or others in need?
9. Could we do something community-wide to help?
1. How can we be more prepared for earthquakes in the future?

Guidelines for Closure

- Summarize the common feelings expressed by the group members.
- Emphasize that we all have the same or similar feelings, fears, and possibly some of the same losses.
- When we recognize our losses, it is normal to grieve for those losses. Explain what grief is and that it is normal. Explain that it is OK to cry, and it is good to talk about it.

- To build a sense of control and security back into their lives, assist group members in selecting a group and/or individual project on which they can work. These projects may include preparedness, community clean-up, rebuilding, etc.
- Refer group members who seem the most traumatized to a counselor or other psychological support personnel.

INTRODUCTION TO

CRISIS INTERVENTION

OTHER RESOURCES

BEST COPY AVAILABLE

Appendix A

TRIAGE ASSESSMENT FORM: CRISIS INTERVENTION

© R.A. Myers, R.C. Williams, A.J. Ottens, & A.E. Schmidt
Northern Illinois University
DeKalb, Illinois

CRISIS EVENT

Identify and describe briefly the crisis situation: _____

_____

_____

AFFECTIVE DOMAIN

Identify and describe briefly the effect that is present. (If more than one effect is experienced, rate #1 as primary, #2 as secondary, and #3 as tertiary.)

Anger/Hostility: _____

_____

Anxiety/Fear: _____

_____

Sadness/Melancholy: _____

_____

1	2 | 3	4 | 5	6 | 7	8 | 9	10
No Impairment Subtle mood with normal variation of effect appropriate to daily functioning.	**Minimal Impairment** Effect appropriate to situation. Brief periods during which negative mood is experienced slightly more intensely than situation warrants. Emotions are substantially under client control.	**Low Impairment** Effect appropriate to situation but increasingly longer periods during which negative mood is experienced slightly more intensely than situation warrants. Clients perceives emotions as being under control.	**Moderate Impairment** Effect may be incongruent with situation. Extended periods of intense negative moods. Mood is experienced noticeably more intensely than situation warrants. Liability of effect may be present. Effort required to control emotions.	**Marked Impairment** Negative effect experienced at markedly higher level than situation warrants. Effects may be obviously incongruent with situation. Mood swings, if occurring, are pronounced. Onset of negative moods are perceived by client as not being under volitional control.	**Severe Impairment** Decompensation or depersonalization evident.

TRIAGE ASSESSMENT FORM: CRISIS INTERVENTION

Cognitive Domain

Identify if a transgression, threat, or loss has occurred in the following areas and describe briefly. If more than one cognitive response occurs, rate with #1 being primary, #2 being secondary, and #3 tertiary

_____

_____

_____

Physical (food, water, safety, shelter, etc.) Transgression ___ Threat ___ Loss ___

Psychological (self-concept, emotional well being, identity etc.) Transgression ___ Threat ___ Loss ___

_____

_____

Social Relationships (family, friends, co-workers) Transgression ___ Threat ___ Loss ___

_____

_____

Moral/Spiritual (personal integrity, values, belief system) Transgression ___ Threat ___ Loss ___

_____

_____

1	2 | 3	4 | 5	6 | 7	8 | 9	10
No Impairment	**Minimal Impairment**	**Low Impairment**	**Moderate Impairment**	**Marked Impairment**	**Severe Impairment**
Concentration intact. Client displays normal problem-solving and decision-making abilities. Client's perception and interpretation of crisis event match with reality of situation	Client's thoughts may drift to crisis events but focus of thoughts is under volitional control. Problem-solving and decision-making abilities minimally affected. Client's perception and interpretation of crisis match with reality of situation.	Occasional disturbances of concentration. Client perceives diminished control over thoughts of crisis event. Client experiences recurrent difficulties with problem-solving and decision-making abilities. Client's perception and interpretation of crisis event may differ substantionally with reality of situation	Frequent disturbance of concentration. Intrusive thoughts of crisis event with limited control. Problem-solving and decision-making abilities adversely affected by obsessiveness, self-doubt, confusion. Client's perception and interpretation of crisis event may differ noticeably with reality of situation.	Client plagued by intrusiveness of thoughts regarding crisis event. The appropriateness of client's problem-solving and decision-making ability likely adversely affected by obsessiveness, self-doubt, confusion. Client's perception and interpretation of crisis event may differ substantially with reality of situation.	Gross inability to concentrate on anything except crisis event. Client so afflicted by obsessiveness, self-doubt, confusion that the problem-solving and decision-making abilities have "shut down." Client's perception and interpretation of crisis event may differ substantially from the reality situation so as to constitute a threat to the client's welfare.

TRIAGE ASSESSMENT FORM: CRISIS INTERVENTION

© R. A. Myers, R.C. Williams, A. J. Ottens
Northern Illinois University
DeKalb, Illinois

Behavioral Domain

Identify and describe briefly which behavior is currently being used. (If more than one behavior is utilized, rate with #1 being primary, #2 being secondary, and #3 tertiary

Approach:

_____

_____

Avoidance:

_____

_____

Immobility:

_____

_____

1	2 | 3	4 | 5	6 | 7	8 | 9	10
No Impairment	**Minimal Impairment**	**Low Impairment**	**Moderate Impairment**	**Marked Impairment**	**Severe Impairment**
Coping behavior is appropriate to crisis event. Clint performs those tasks necessary for daily functioning.	Occupational utilization of ineffective coping behaviors. Client performs those tasks necessary for daily functioning, but does so with noticeable effort.	Occupational utilization of ineffective coping behaviors. Client neglects some tasks necessary for daily functioning, performs others with decreasing effectiveness.	Client displays coping behaviors that may be ineffective and maladaptive. Ability to perform tasks necessary for daily functioning is markedly compromised.	Client displays coping behaviors that are likely to exacerbate crisis situation. Ability to perform tasks necessary for daily functioning is markedly absent.	Behavior is erratic, unpredictable. Client's behaviors are harmful to self and/or others.

DO'S & DON'TS OF PSYCHOLOGICAL FIRST AID

From ***Crisis Intervention: A Handbook for Practice and Research***
By
Karl A. Slaikeu

DO	DON'T
1. Making Contact	
Listen Carefully	Tell your *own story* yet
Reflect feelings & Facts	Ignore either Facts or Feelings
Communicate Acceptance	Judge or take sides
2. Dimensions of problem	
Ask open-ended questions	Rely on yes/no questions
	Ask the person to be specific
	Allow continued abstractions
Assess lethality	Ignore *danger* signs
3. Possible solutions	
Encouraging brainstorming	Allow tunnel vision
Deal directly with blocks	Leave obstacles unexplored
Set priorities	
4. Concrete action	
Take one step at a time	Attempt to solve it all now
Set specific short-term goals	Make binding long-term decisions
Confront when necessary	Be timid
Be directive, if and only if necessary	Retreat from taking responsibility
5. Follow-up	
Make a contract for recontact	Leave details up in the air or assume the client will follow through on a plan on his or her own
Evaluate action steps	Leave evaluation to someone else

Crisis Symptoms and Treatment Strategies

From "Community disasters: Primary prevention and treatment in a health maintenance organization," ***American Psychologist***, 34:334-338 (1979)
By L. I Sank

As quoted in
Crisis Intervention: A Handbook for Practice and Research
By Karl A. Slaikeu, Allyn and Bacon, Inc. Boston, 1984

Symptoms	Treatment Modality
Behavior	
Avoidance	In vivo systematic desensitization
Crying/verbally snapping at others	Deep muscle relaxation, assertiveness
Effect	
Muted effect	Group sharing of experience or writing down feelings
Mild depression	Planning rewarding activities, reassurance
Anxiety attacks	Deep muscle relaxation, coping imagery, assertiveness training
Anger	Assertiveness training
Sensation	
Sleep disturbances	Deep muscle relaxation, scheduling usual relaxing activities, exercise, coping imagery
Headaches	Deep muscle relaxation with concentration on muscles of the face, neck, and shoulders
Stomach and bowel disturbances, muscle tightness, back pains	Deep muscle relaxation with concentration on trunk muscles
Fatigue	Permission to sleep more and less rigorous activities

Crisis Symptoms and Treatment Strategies
(continued)

Imagery	
Reliving of takeover or Holocaust fantasies	Substituting calming imagery, focus on release
Being vulnerable in all life situations	Assertive imagery
Cognitions	
Obsessive thoughts	Thought stopping
Awfulizing	Encourage feedback from group members on behavior during takeover
"This wouldn't have happened if only . . ."	
"I should have . . ."	
"I wasn't a hero, and I should have been . . ."	
Catastrophizing	Rational emotive therapy
"I'll never get over this . . ."	
"The (insert name) know my name and address and will come to kill me later."	
"No place is safe anymore."	
Isolation	
"I'm the only one who has had these reactions.:	Group sharing, with therapists providing limited information about the wide variety of reactions to stress
Interpersonal	
Increased dependency and human contact	Coping imagery, assertion training, permission to need the comfort of others
Suspicious of strangers	Take more realistic precautions (lock car and home, etc.) in vivo desensitization
Marital conflict	Assertion training and referral to family therapist
Drugs	
Increased use of tranquilizers, medications, or alcohol	Substitution of deep muscle relaxation, exercise, rational emotive therapy, coping imagery, limited use of drugs when appropriate

CRISIS MANAGEMENT PLANNING CHECKLIST
Reprinted with permission from SWRL

- ☐ Define crisis for your school.
- ☐ Decide who will be in charge during a crisis.
- ☐ Select your Crisis Response Team.

Develop appropriate policies and procedures for handling crisis situations.

- ☐ Before it happens ☐ When it happens ☐ Postcrisis follow-up
- ☐ Train the CRT.
- ☐ Establish a police liaison.
- ☐ Establish a media liaison and plan for contacting media.
- ☐ Establish a working relationship with community service providers and develop a list of telephone numbers and contact persons.
- ☐ Set up phone trees.
- ☐ Create or reserve space for service providers involved in crisis management and for community meetings.
- ☐ Develop and print forms to assist in crisis management.
- ☐ Develop a plan for emergency coverage of classes.
- ☐ Establish a code to alert staff.
- ☐ Develop a collection of readings.
- ☐ Obtain legal review of crisis response procedures and forms.
- ☐ Hold a practice crisis alert.
- ☐ Establish procedures for annual in-service of new staff and update/review for all staff.

GENERAL CRISIS INTERVENTION CHECKLIST
Reprinted with permission from SWRL

- ☐ Direct staff and others not to repeat information until verification is obtained.
- ☐ Notify superintendent
- ☐ Convene CRT and assign duties.
- ☐ Notify the building support staff, such as counselors, psychologists, and/or social workers.
- ☐ Inform closest friends of the affected student and provide support.
- ☐ Prepare formal statement or announcement.
- ☐ Announce time and place of the emergency staff meeting.
- ☐ Identify other/additional students, staff, and parents likely to be most affected by news.
- ☐ Assess need for additional community resources.
- ☐ Assign trained staff or community professionals to:
  - ☐ Provide grief support to students;
  - ☐ Review and distribute discussion questions to teachers;
  - ☐ Stand in for absent/affected/substitute teacher; and
  - ☐ Distribute lists of community resources.
- ☐ Make official announcement.
- ☐ Hold emergency staff meeting.
- ☐ As needed, assign team members and other staff to monitor the grounds; notify the parents, support staff and feeder schools; provide support to staff; collect student belongings, and withdraw student from the school rolls.

CHECKLIST FOR LONG-TERM FOLLOW-UP

Reprinted with permission from SWRL

- ☐ Gather faculty for update.
- ☐ If acceptable to family, provide funeral information.
- ☐ Identify students requiring additional support and assign staff to monitor.
- ☐ Debrief with CRT.
- ☐ Provide opportunity for staff to discuss feelings and reactions.
- ☐ As appropriate, provide a list of suggested readings to teachers, parents, and students.
- ☐ Amend crisis response procedures as necessary.
- ☐ Monitor crisis anniversaries.

Long-term Follow-up to Crisis Situations
Reprinted with permission from SWRL

The following information may be useful in the days and weeks following a crisis Longer term follow-up procedures also are listed.

The Day After: Workday Two of Crisis Management

1. Gather faculty members and update them on any additional information/procedures.
2. In case of death, provide funeral/visitation information if affected family has given permission.
3. Identify students in need of follow-up support and assign staff members to monitor each of these vulnerable students:
    a. coordinate any ongoing counseling support for students on campus;
    b. announce ongoing support for students with place, time, and staff facilitator; and
    c. notify parents of affected students regarding community resources available to students and their families.
4. Convene Crisis Response Team for debriefing as soon as possible:
    a. discuss successes and problems; and
    b. discuss things to do differently next time.
5. Allow staff an opportunity to discuss feelings and reactions.

Long-Term Follow-up and Evaluation

1. Provide list of suggested readings to teachers, parents, and students.
2. Amend crisis response procedures as necessary.
3. Write thank-you notes to out-of-building district and community resource people who provided (or are still providing) support during the crisis.
4. Be alert on crisis anniversaries and holidays. Often students will experience an "anniversary" grief reaction the following month or year on the date of the crisis, or when similar crises occur that remind them of the original crisis. Holidays, too, often are difficult for students who have experienced loss.

OFF-TRACK/SUMMER CRISIS INTERVENTION CHECKLIST

Reprinted with permission from SWRL

- ☐ Institute the phone tree to inform CRT members.
- ☐ Identify and make a list of students and staff members most likely to be affected.
- ☐ Notify staff members or families of students identified and recommend community resource people who can provide support.
- ☐ Notify remaining staff with appropriate information by letter or telephone.
- ☐ Schedule faculty meeting for an update before affected students return to school.
- ☐ When school reconvenes, monitor students and staff members previously identified.
- ☐ Make appropriate referrals for students or staff members who need additional help.

YOUTH SUICIDE

Although this section was written for the school counselor who deals with students, the information given can be adapted for any age group.

Reprinted with permission from the Suicide Prevention Unit, Los Angeles Unified School District, Bellagio Road Annex, Room #4, 11301 Bellagio Road, Los Angeles, CA 90049 (310) 472-4744

Youth Suicide

Background

Suicide and other self-destructive behaviors have reached epidemic proportions among our nation's youth. Since 1950, the suicide rate in the 10-19 age range has quadrupled, where rates of other high risk groups have predominantly stayed the same. Today, suicide is second only to accidents as the leading cause of death for 10-19 year-olds. If the age range is extended to include 24 year-olds, suicide is the third leading cause of death behind accidents and homicide. Although these numbers seem staggering, all suicide statistics are generally considered underestimates. Recent research indicates that in this year alone, a million attempts will be made by children in this age range. The Carnegie Foundation has characterized our youth as a *Generation At-Risk,* while a recent Center for Disease Control (1990) study estimated the at-risk population of children and adolescents to be as high as 28%. This risk of suicide cuts across all ethnic and economic boundaries.

Suicidal youth are characterized by their ambivalence. This ambivalence is expressed through feelings of wanting to die (or be out of pain) and wanting to live, both of which occur at the same time. This ambivalence is what makes suicide prevention possible.

Many children do not understand the permanency of death. To the younger child, death and suicide can be turned off and on like a fantasy. This child may use the suicide threat to inform the parents

of the need for greater attention. To the older child, suicidal threats or attempts may be seen as the only means to communicate anger or to punish the parents. Adolescence is a time of establishing identity and developing life skills. Some adolescents try to escape from reality with drugs, while others see suicide as the means of solving their problems. Much of what is written about adolescents also applies to college-aged youths. No matter at what age they occur, all threats of suicide must be taken seriously.

A microcosm of a suicide attempt generally contains two factors. The first, an acute factor, is a precipitating event which can be seen as *the straw that breaks the camel's back*. This event occurs to a child who possesses the second factor, chronically poor coping skills. Herein lies a key to prevention. If we can strengthen a child's coping skills (i.e., raising self-esteem, increasing communication skills, getting along well with others, and developing and reaching goals), then he or she may not seek suicide as a means to solve a problem.

Another key to prevention lies in becoming more sensitive to the stressors that face today's youth. Educators must become more knowledgeable and be able to recognize the risk factors and warning signs of youth suicide.

Societal Stressors

Our society is forever changing to accommodate the demands of overpopulation and explosive advances in the technological fields. With this rapid growth, people have had to constantly adapt and adjust just to keep their *heads above water*. The ability to keep pace and cope with life's unexpected turns has produced more stress in our lives. Unfortunately, our young people are not immune to this distress as they go

about the challenges of growing and finding their own identity in such a complex world.

Educators have witnessed these rapid changes in the schools as well. Once concerned with gum chewing and running in the halls, the modern educator must now deal with such serious youth problems as children having children, alcohol and substance abuse, gang warfare, and the prevalence of guns and violence in our communities. Today, 22% of our nation's youth live in poverty. In 1993, 40% of those living in poverty were children under the age of eighteen.

The face of the American family is also changing. As divorce rates climb, it is estimated that 62% of today's three-year olds will live in a single parent home before they reach the age of eighteen. With these changes, many young people must cope with increased responsibilities at home and a lack of support systems within which to grow.

These are just some of the stressors that our children must face. Others include peer pressures, fear of war, and a media that constantly sensationalizes violence, devalues life, and offers quick fixes to complex problems.

Many young people are able to deal with these types of stressors and cope with life's unexpected turns. Others become increasingly more disabled by what happens in their lives and experience difficulty functioning on a daily basis. These are the young people that become *at-risk*, a risk that may lead them to consider suicide.

Risk Factors

- Previous attempts or completions of suicide in the family
- Family problems such as abuse, neglect, or violence in the home
- Sexual orientation confusion
- Preoccupation with death themes

- Run-away/truancy
- History of drug or alcohol abuse
- Involvement with the law
- Losses (through death, divorce, break-ups including pets)
- Chronic health problems
- Rejection or humiliation
- Decline in school/academic performance

Warning Signs

As the young person moves down this path of self-destructive behavior, they often give clues, which are seen as warning signs, that reveal their intentions. **Take all threats seriously.** By threatening suicide, a child is calling for help. The warning signs of suicide are:

- Previous attempts
- Threats
- Plan or method (availability of means)
- Giving away prized possessions
- Pervasive depression, isolation or withdrawal
- Feelings of helplessness, hopelessness, or anger at self and/or the world
- Sudden changes in behavior, dress, or social milieu
- Risk-taking behaviors or efforts to hurt one's self (i.e., running into traffic or jumping from high places)

If you observe, or are informed of, any of these warning signs, begin the intervention process immediately. Guidelines for this process are provided in the next section, **Crisis Intervention and Suicide.**

Crisis Intervention and Suicide

CONFIDENTIALITY The complex area of confidentiality is addressed in the California Education Code, Section 49602, which states that "*any information of a personal nature disclosed by a pupil 12 years of age or older in the process of receiving counseling from a school counselor is confidential.*"

However, there are numerous exceptions to this principle that are also spelled out in this section. One includes reporting "*clear and present danger to health, safety or welfare.*" The California Legal Advisory (Department of Education, 4/21/88, ***Duties and Liabilities of School Counselors***) states "*personal information disclosed during counseling is confidential, unless failure to disclose would endanger someone's health and safety or conceal the commission of a crime. When counselors become aware that a child receiving counseling is a serious danger to themselves or to third parties,* ***THE COUNSELOR MUST MAKE APPROPRIATE REFERRALS AND/OR WARN APPROPRIATE PARTIES OF THE DANGER***" (see Step #2 in "The Intervention Process").

COLLABORATION It is recommended the counselor collaborate with other members of the school's crisis team in responding to the referral of a suicidal child or adolescent. The child may need to be monitored by one member while the counselor attempts to secure help for the child by telephone. The counselor's individual liability is protected when he or she is functioning in the best interests of the child as part of a crisis team. In addition, the assessment process is best conducted when information is gathered from numerous personnel who have had first-hand experience with the child.

GENERAL ACTIONS (Psychological First Aid) The general principles of psychological first

aid apply here. One who is trained and prepared will have more confidence in crisis situations. A suicidal youth requires sensitivity and strong leadership from the school counselor to get the help they need. The counselor will be modeling many essential coping skills that the young person may call on in the future when they confront other stressors and challenges in their lives. Other good general practices to follow are:

- Offer support, understanding and compassion.
- Confront the problem openly. Be direct; and do not be afraid to discuss suicidal intention with the person. Getting him or her to talk is a positive step and models good communication skills.
- Listen! Try to understand what the individual is feeling without making judgments or trying to minimize his or her pain.
- Be affirmative and supportive. Isolation is one of the worst conditions for someone who is suicidal.
- In your interactions with a suicidal individual, do everything possible to preserve his or her dignity, self-worth, and sense of personal value.

The Intervention Process

Each school district is strongly encouraged to establish a process for identifying students at-risk and providing direct intervention and referral services for them and their families. Because each referral is unique, the typical steps in the process are summarized in the section that follows.

Step #1: Assessment of Risk

When a member of the staff, a parent, the student, or a friend of the student refers a student at-risk to a school counselor, the counselor is urged to collaborate with at least two other members of the crisis team, the

referring individual, the referred child, and the parents on all steps of the process (see Step #2).

Identify and assess the current stressors and symptoms of the child, the specifics of the suicide plan, the presence of risk factors or any significant background, and develop a plan of action to provide help for the referred child. Do not be afraid to ask the tough questions (i.e., "Many people like you who have thought of suicide, have thought of a way they might do it . . . have you thought of a way?)"

Then determine if the child has access to any method mentioned. Consider the age of the child ... a preschool child who jumps from a chair or a middle school adolescent who takes a few pills can be considered attempting suicide.

Step #2: Warn the Parents

Parents must be informed whenever a child is referred due to suicidal behavior. However, if collaboration has revealed an open case with the Department of Children's Services or if there is a strong indication that warning the parents would place the child in further danger, contact and involve the Protective Children's Services or local law enforcement agency.

If there is no indication of abuse, past or present, and the child seems emotional and afraid of your intention to call the home, keep in mind that a suicidal child may be impaired in their judgment and not thinking clearly. When in doubt, collaborate on your action plan. When collecting assessment data from the parents, it is always helpful to obtain the family's health insurance information as it will prove essential in following through as indicated in step #3.

Step #3: Provide Community Referral Resources

If the family has no insurance, referral should be made to a non-proprietary (i.e., public, non-profit) agency that serves the area in which the child resides.

If the family has insurance, refer to the insurance provider, especially if an Health Maintenance Organization (HMO; e.g., Kaiser)

Step #4: Follow-up and Support Family

A. If High-Risk:

1) Contact agency and provide pertinent referral information.
2) Follow up to insure arrival at agency. If necessary, assist parent in getting to the agency.
3) Get parent signature on "Parent Authorization for Release of Information" form for future consultation with agency staff.
4) Develop with parent and crisis team members local school support strategies such as program modifications or referral to school support groups.
5) **If parent is UNAVAILABLE:**
   a) At the discretion of the school site administrator, select two members of the crisis team to escort the child to the nearest emergency mental health facility and coordinate with agency's Social Services on continuing to contact parent.
   b) Some Department of Mental Health agencies have local Psychiatric Mobile Response Teams available to assist in transporting a suicidal child.
   c) Some local police or law enforcement agency may also be able to offer assistance with transportation.
6) **If parent is UNCOOPERATIVE:**
   a) Some parents may be slow or reluctant to follow through on getting services for their child. Give parents the appropriate opportunity and encouragement to follow through before collaborating with crisis team members on when to proceed to the next step.

b) Contact the local law enforcement agency (police or sheriff) or the Department of Children's Services (DCS).
c) Report the incident as child neglect/endangerment if the parents are contacted but will not cooperate.

B. If Minimal or Moderate Risk:

1) Assist parent in getting an appointment, and if appropriate, provide pertinent information to the agency. Follow up to determine if the appointment was kept.
2) Develop local school support strategies.

DOCUMENTATION For the protection of the school district, the school, and the school counselor, all actions and every step of the referral process should be documented upon completion.

For the Returning Student

When a person returns from a hospitalization for a mental health problem such as **depression** or a **serious suicide attempt**, follow these steps.

1. The student should be directed to go to their counselor or a member of the crisis team upon their return to school. Coordinate with the attendance office personnel so you will be notified of the person's return. You can tag the absence slip, or have the crisis team determine the procedure, but be aware when the return occurs.
2. Welcome the student and help ease their transition back to school. Assist the student in communicating with staff members, while respecting the confidentiality of the child.
3. Work with the person and crisis team to provide school support strategies such as a monitoring system or participation in a support group.

In the Aftermath of Suicide

In the aftermath of a student's suicide, the function of the crisis team is to assess the degree of impact on the school population and advise the principal how to proceed. The crisis team initiates the action plan and often provides direct psychological first aid to the students and staff. Some additional suggested guidelines for management in the aftermath of a suicide at a school are:

1. The Principal meets with the site crisis team and develops an action plan to be followed. If necessary, a phone tree can be activated to inform the staff of the tragedy and their required attendance at a special faculty meeting.
2. A fact sheet containing all the know facts should be written and distributed to the faculty and students. It is advisable to take the wishes of the family into consideration in writing this statement. If the police are involved in an investigation, they too, should be consulted.
3. Students should be allowed the opportunity to express their reactions in whatever setting is most comfortable, either through individual sessions, classroom discussions, or small group participation.
4. Emphasis should be placed on the fact that grief is a normal reaction; therefore, students should be allowed to express their feelings through discussion, creative writing, drawing, puppetry, and music.
5. Students should be permitted to participate in discussions concerning depression and the finality of death and suicide. The issues of guilt and responsibility should be addressed.
6. Establishing a central crisis room can be helpful, so that students needing or wanting more individual help can work directly with crisis

team members. Identify breakout rooms for individual sessions, if necessary.

7. Contagion is a concern after a completed suicide. Students who were close to the victim should be identified and monitored along with anyone else who may have a strong reaction to the suicide. Those students who were previously identified as *at risk* for suicide should also be monitored (see **Identifying Students At Risk** and **Contagion**).
8. No memorials or dedication should be allowed. (see **Glorification**).
9. The crisis team should assign a member to act as the spokesperson to provide information and communication to the media. It is important to stress the need to not sensationalize the suicide (see **Media**).
10. Teams are encouraged to have at least one parent member to assist in addressing parental concerns. A fact sheet should be provided for all parents. The information should include the facts regarding the incident, the school's intervention plans, and the names of team members who are available for additional assistance. A handout listing the warning signs of suicide should be included as well as a list of community agencies that parents can contact for further consultation. Parents and children should be encouraged to discuss their feelings and concerns with each other.

Identifying Students at Risk

In the aftermath of a suicide, like any other traumatic event, everyone in the immediate community elevates in risk. Not only may the persons close to the victim exhibit a variety of emotions, but

even those who did not know the deceased may show reactions as well.

Each person is affected differently by a traumatic experience, and their responses may be influenced by their own individual *trauma pool*. One focus of the action plan is to identify those who may now be in need of additional help. Some of the signs that help identify such persons are:

- Uncontrollable crying
- No emotional response from a person who was close to the victim
- Exhibiting anger while most in a classroom are displaying sadness
- A lot of emotional reactions from someone who hardly knew the deceased
- A person who is emotionally unstable, one who may have felt suicidal in the recent past, or those individuals with exceptional needs may have a strong reaction to the suicide and also be in need of additional help.

Clusters

Recent clusters of suicides among teenagers and young adults have brought to light a complex problem facing communities in the aftermath of a suicide although research on this issue is far from complete. A **suicide cluster** may be defined as a group of suicides or suicide attempts, or both, that occur closer together in time and space in a given community than would normally be expected. The Center for Disease Control's pamphlet, "Prevention and Containment of Suicide Clusters," has provided guidelines to assist communities in dealing with this problem. Some of the material from the pamphlet is included here to highlight significant post-suicide intervention, or postvention, issues.

Contagion

Clusters of completed suicides occur predominantly among adolescents and young adults and account for approximately 1%-5% of all suicides in this age group. They are thought by many to occur through a process of *contagion*. Though this hypothesis has not yet been formally tested, evidence suggests that in any cluster: 1) suicides that appear late in the cluster appear influenced by those appearing earlier in the cluster; and 2) exposure of the community population to suicide through television or other media outlets may increase the risk of suicide for certain susceptible individuals.

If a cluster of suicide completions or attempts in your school community has engendered intense concern on the part of the school crisis team, staff, parents, students, or others, it is recommended that the school take a leadership role in coordinating a community response to the problem.

Glorification

It is critical to allow children and adolescents the opportunity to grieve in the aftermath of a suicide. However, spokespersons should avoid glorifying the decedents or sensationalizing their deaths in any way. To do so might increase the likelihood that someone who identifies with the decedent or who is having suicidal thoughts will also attempt suicide in order to be similarly glorified or to receive similar positive attention. Dedications and memorials such as those that might appear in a yearbook or graduation should be avoided. Funeral services should not be allowed to unnecessarily disrupt the regular school schedule. Attendance at such should be left to the discretion of a student's family.

Media

The presence of the media can be immediate in the aftermath of tragedy, and they can present a host of problems for an intervention team. The school has a right to set parameters for the press and TV. Rather than ignore or take an adversarial approach to the media, it is to the advantage of the intervention team to work with them. Establishing firm guidelines in advance is the best way to be prepared.

1. Assign a single media spokesperson and make certain that a single account of the situation is presented.
2. Assign the media to a controllable area, and do not allow them to wander around on campus at any time.
3. Gather all of the information before talking to the press, and verify the information to insure its accuracy. Use prepared notes if necessary and say, "I don't know," or "I'm not sure of that information, but I will find out and get back to you," when appropriate.
4. Discuss the positive steps being taken, and try to get the media to assist in the response by reporting what warning signs parents can look for and where troubled persons can go for help.
5. The precise nature of the method(s) used by the decedent(s) in completing suicide should not be disclosed. Such revelations can make imitative suicides more likely.
6. Interviews by the media with peers or students can be very stressful. Do not allow such interviews on campus at any time.
7. Try to have the media avoid putting the article on the front page. If they must, it should be placed below the fold. There should be no photo of the victim and the word *suicide* should not be used in the headlines.

YOUTH SUICIDE

OTHER RESOURCES

BIBLIOGRAPHY

Some of the material included in this chapter was adapted from the following resources.

Crossroads: Coping with Crisis, The Youth Suicide Prevention Program of Los Angeles Unified School District. LAUSD,1987.

A Handbook for Crisis Intervention. Los Angeles Unified School District, Revised 1990.

The California Helper's Handbook for Suicide Intervention. Office of Prevention, California State Department of Mental Health.

Center for Disease Control Recommendation for a Community Plan for the Prevention and Containment of Suicide Clusters. Division of Injury Epidemiology and Control Morbidity and Mortality Weekly Report, Volume 37. No. S-6 August 19, 1988.

Stress and Adolescence

Barnett, Tom. Youth in Crisis: Seeking Solutions to Self-Destructive Behavior. Longmont, Colo.: Sopris West, 1986.

Elkind, D. The Hurried Child: Growing Up Too Fast Too Soon. Reading, Mass.: Addison-Wesley, 1981.

Hafen, Brent and Kathryn Frandsen. Youth Suicide: Depression and Loneliness. Evergreen, Colo.: Cordillera Press, 1986.

Joan, Polly. Preventing Teenage Suicide: The Living Alternative Handbook. New York: Human Sciences Press, 1987.

Johnson, Kendal. Classroom Crisis: A Readi-Reference Guide. Claremont, CA.: Turnpoint Publishing, 1987

LeShan, E. You and Your Feelings. New York: Macmillan, 1975. (Also appropriate for young adults.)

McCoy, K. Coping with Teenage Depression: A Parent's Guide. New York: New American Library, 1982.

Myers, I., and Myers, A. Why You Feel Down and What You Can Do About it. New York: Scribners, 1982.

Suicide: Interpretation, Prevention, and Intervention

Alvarez, A. The Savage God: A Study of Suicide. New York: Random House, 1976.

Berman, A.L., and Jobes, D.A. Adolescent Suicide: Assessment and Intervention, Washington, D: American Psychological Association, 1991.

Farberow, N.L., ed. Many Faces of Suicide: Indirect Self-Destructive Behavior. New York: McGraw-Hill, 1979

Finch, J.M., and Poznanski, E. D. Adolescent Suicide. Springfield, Ill.: Charles C. Thomas, 1971.

Forsythe, E., and Hyde, M. Suicide: The Hidden Epidemic. New York: Franklin Walls, 1978.

Friedman, P. On Suicide: With Particular Reference to Suicide Among Young Students. New York: Doubleday, 1983.

Griffin, M., and Felsenthal, C. A Cry for Help: Explaining and Exploding Myths about Teenage Suicide. New York: Doubleday, 1983

Giovacchini, P. The Urge to Die: Why Young People Commit Suicide. New York: Penguin, 1983.

Haim, A. Adolescent Suicide. Translated by A.M. Sheridan Smith. New York: International University Press, 1970.

Hendin, H. Suicide in America. New York: W.W. Norton, 1982.

Hipple, J., and Combolic, P. eds. The Counselor and Suicidal Crisis: Diagnosis and Intervention. Springfield, Ill.: Charles C. Thomas., 1979.

Jacobs, J. Adolescent Suicide. New York: Wiley, 1971.

Kiev. A. The Courage to Live. New York: Thomas Y. Crowell, 19790.

Klagsburn, F. Too Young to Die: Youth and Suicide. New York, Pocket, 1981.

Leenaars, A. and Wenckstern, S., ed. Suicide Prevention in Schools. Washington, D: Hemisphere, 1990. New York: Springer, 1985.

Lettieri, D. J., ed. Drugs and Suicide: When Other Coping Strategies Fail. Beverly Hills, CA.: Sage, 1979.

Mack, J.E., and Hickler, H. Vivienne: The Life and Suicide of an Adolescent Girl. Boston: Little, Brown, 1981.

Madison, A. Suicide and Young People. New York: Seabury Press, 1978.

McIntire, M., and Angle, C. Suicide Attempts in Children and Youth. New York: Harper and Row, 1980.

National Clearinghouse for Mental Health Information. Child and Adolescent Suicide. Rockville, Md.: U.S. Department of Drug Abuse and Mental Health Administration, National Institute of Mental Health, 1981.

Peck, M.L., Farberow, N.L., and Litman, R.E., eds. Youth Suicide. New York: Guilford.

Pfeiffer, C.R. The Suicidal Child. Publications, 1978.

Rabkin, B. Growing Up-Dead. Toronto: McClelland and Stewart, Ltd.,1978.

Ross, C. "Teaching Children the Facts of Life and death: Suicide Prevention in the Schools.11 In Peck, M.L., Farberow, N.L., and Litman, R.E., eds., Youth Suicide. New York: Springer, 1985.

Seiden, R.H. Suicide Among Youth. Publication No. 1971. U.S. Government Printing Office, Public Health Service. Chevy Chase, Md.; 1969.

Schneidman, E.S., and Farberow, N.L., eds. Clues to Suicide. New York: McGraw-Hill, 1957.

Schneidman, E.S., Farberow, N.L., and Litman, R.E. The Psychology of Suicide New York: Science House, 1970.

Sudak, H. Ford, A.B., and Rushforth, N.B., eds. Suicide in the Young. Boston: John Wright/PSG, inc., 1984.

SUICIDE ATTEMPT CHECKLIST
Reprinted with permission from SWRL

- ☐ School involvement regarding the incident is due to:
  - ☐ Rumors and myths that are widespread and damaging.
  - ☐ Police action/emergency services witnessed by students; and
  - ☐ Survivor's friends requesting intervention.
- ☐ Information providers/recipients enjoined not to repeat information elsewhere.
- ☐ Steps taken to protect attempt survivor's right to privacy.
- ☐ Action taken to quell rumors.
- ☐ CRT member closest to attempt survivor met with friends to determine support needed.
- ☐ Space provided on site for identified peers to receive support services.
- ☐ School reentry procedures followed
- ☐ All records related to incident and services provided stored in confidential file.

SUICIDAL RISK CHECKLIST
Reprinted with permission from SWRL

- ☐ School administrator notified.
- ☐ Parent/guardian notified or emergency contact notified.
- ☐ Mental health service provider (on site or external) notified and severity assessment requested.
- ☐ Other actions taken (specify):

_____

_____

_____

Social Unrest

Social Unrest

Introduction

Social unrest consists of a variety of problems: vicious rumors, demonstrations, acts of civil disobedience, and full scale riots. In times of social unrest, it seems to some people that citizens have read Jean Jacques Rousseau's political treatise, ***Social Contract,*** in which he advocates that people "have a duty to obey only legitimate powers." To others, it seems that all respect of authority has vanished and anarchy rules.

Anecdote

Shortly after the social unrest in Los Angeles, following the Rodney King trial, one of the contributors to this handbook was supervising a high school campus during a morning break when a fight between two female students broke out. There were about 150 students gathered around the fight as the supervisor made his way to the center where the girls were fighting. The surge of the crowd seem to move them like flotsam in the sea; however, using the existing momentum they were able to move into a nearby building, shut the doors, and with the help of the other supervisors who arrived, break up the fight.

Upon reflection, the supervisor realized that in a high school setting where students outnumber the staff often 100 to 1, the only way the staff can control the situation is through the consent and cooperation of the students. There is no way 100 to 125 adults can maintain authority over 1800 to 2000 young adults between 14 to 18 without their tacit approval and permission. There seems to be an unwritten social contract.

CACD members can best prepare themselves for situations involving social unrest by initiating proactive measures in their institutions and having plans and procedures in place for appropriate action if the unwritten *social contract* is broken and violent unrest breaks out.

Proactive Measures for Social Unrest

Proactive measures for social unrest that can be taken are as follows:

- In school settings, establish a student government that is active and effective.
- In non-educational settings, establish procedures for listening and responding to complaints and grievances.
- Utilize peer counselors as helpers and role models.
- Implement a mentor program for those individuals who are isolated or disenfranchised.
- Encourage and train staff members to treat all individuals with respect on a daily basis.
- Establish an institutional culture that is sensitive to and respects cultural differences and diversity through training and in-service sessions.
- In educational settings, create plans for discipline that focus on logical consequences rather than punishment.
- In schools, change the curriculum to meet the needs of students.

Responding to Non-Violent Social Unrest

When an institution is not responsive to the needs of its members and does not seek input in decision

making, the climate for unrest is created. When unrest does break out, counselors need to be prepared with plans and procedures.

Responses to social unrest situations involving non-violent acts like demonstrations, sit-ins, strikes, etc. may be dealt with through Conflict Resolution and negotiating techniques and strategies.

Conflict Resolution, or **Dispute Resolution,** consists of strategies that are being used more and more by courts and mediation services for resolving conflict and disputes. These strategies rely heavily upon communication skills such as active listening (see information sheets in **Social Unrest: Other Resources** found at the end of this section).

Responding to Violent Social Unrest

However, when a staff does lose control and students or the organization's members become violent, response needs to be quick and decisive with intervention by law enforcement agencies.

- Meet with your organization's staff and brainstorm potential violent unrest situations to develop an action plan.
- Consult with local law enforcement officials, review your action plan, and develop procedures and guidelines for involving law enforcement.
- After order has been reestablished, call together student leaders on campus and resource people from the community to facilitate groups involving the different factions.
- Establish a process for dealing with rumors and resolving the tensions that rumors create.
- Develop a plan to utilize the groups representing the different segments of your organization and meet with them several times to establish and maintain communication and understanding.

Reducing Tension

The following procedure was followed to reduce racial tension at a local campus. An altercation had occurred between Anglo students and Mexican-American students in the cafeteria.

Two counselors (one Anglo and one Mexican-American) called in an outside consultant to help facilitate the groups. The three counselors set up the following plan.

First Meeting
Purpose: Determine what happened
Attendees: Those parties and witnesses involved in the fracas.

- Individuals state exactly what was said and done in the incident.
- Each person states exactly how it made them feel.
- Information is recorded.

Second Meeting
Purpose: Reinforce what happened and dispel rumors.
Attendees: Those parties and witnesses involved. Selected student leaders whose judgment is valued.

- Review what happened and what was said.
- Record discrepancies only.

Third Meeting

Purpose: Continue to dispel rumors and create a better situation

Attendees: Those parties and witnesses involved.
Second Meeting participants
Expand student leader groups to include:
Class leaders.
Key leaders of athletic teams (2 Anglo and 2 Mexican-American)
Student government leaders (2 Anglo and 2 Mexican-American)

Main Task: What can be done to improve the situation?

- Alternate seating in a circle. Students from the same group may not sit next to each other.
- Students report to home room and senate meetings.
- Counselors report to all staff members (including maintenance, cafeteria, and bus personnel.

Fourth Meeting

Purpose: Review and follow-up

- Attendees:
  All persons from third meeting
- Discussion
- Accomplishments and direction

Main Task: Culture Responsive sessions (as needed)

After Order is Restored

Frequently there is a tendency to breathe a sigh of relief when order is restored and the dust settles; but this is when mistakes are made. One of these mistakes is thinking the problem has been resolved and dealt with, so now we can stop and rest on the small steps that have been taken. However, this is the

time we must use our good communication skills daily to maintain the peace.

In school settings when a student is late, we have the opportunity to say, "What's the matter with you? Why are you always late?" or we have the opportunity to say, "How can I help you to be on time?" A little kindness and tact goes a long way in forming positive relationships. The same student you helped may be the very leader who will support you when you need it the most.

An activity that is useful in demonstrating the barriers to accurate listening is the **Rumor Mill**. From it, the participants will learn how difficult it is for a story to remain true to its first telling.

Rumor Mill

Show a group of people a picture of any incident. Have three additional persons remain in the hallway. Bring one of those persons into the room where the group is and show him or her the same picture. Then have the observer go back out into the hallway and tell what he or she saw in the picture to one of those waiting there. The second person then tells the third person what he or she heard.

The third person then comes into the room and reports to the group what was described to him or her. The group will see that even though the people knew they were involved in a listening activity, there was still distortion of the facts as the story was repeated. They can then imagine the distortion of facts when it is an actual incident.

Social Unrest

0ther Resources

Active Listening Techniques

Statements	Purpose	To do this . . .	Examples
Encouraging	1. To convey interest 2. To encourage the other person to keep talking	. . .don't agree or disagree . . .use neutral words . . .use varying voice intonations	1. "Can you tell me more?"
Clarifying	1. To help you clarify what is said 2. To get more information 3. To help the speaker see other points of view	. . .restate basic ideas and facts . . .Restate wrong interpretation to force the speaker to explain further	1. "When did this happen?"
Restating	1. To show you are listening and understanding what is being said 2. To check your meaning and interpretation	. . .restate basic ideas and facts	1. "So you would like your parents to trust
Reflecting	1. To show that you understand how the person feels 2. To help the person evaluate his or her own feelings after hearing them expressed by someone else	. . .reflect the speaker's feelings	1. "You seem very upset"
Summarizing	1. To review progress 2. To pull together important ideas 3. To establish a basis for further discussion	. . .restate major ideas expressed including feelings	1. "These seem to be the key ideas you've expressed..."
Validating	1. To acknowledge the worthiness of the other person	. . . acknowledge the value of their issues and feelings . . . show appreciation for their efforts and actions	1. "I appreciate your

Saying it Differently

Non-Reinforcing Statements	Reinforcing Statements
Why are you always late?	How can I help you be on time? Should we change your (work or school) schedule?
Where have you been?	We've missed you. Are you OK?
You've done nothing all morning	I'm concerned that this situation isn't making progress possible for you. Are you having difficulty? Let me go over this with you.
Stop talking with_____.	I think it's wonderful that you two are such good friends, but I'm concerned about your progress, too.
Would you settle down – you're disrupting the rest of the class.	You seem to be having trouble concentrating today. Do you need a time out?
Don't talk back to me.	You seem very angry about something. Why don't we try to talk calmly about it? I know you're angry with me, but it would be best if you could try to talk about it quietly.
	"Cussgram": Write down everything you feel like saying to me on a piece of paper. Then stomp on it or tear it up.

The Conflict Mediation Process

Focus

Focus is placed on resolving conflicts without the threat of violence. There is time to practice communication and listening skills and participate in finding mutually agreed-upon solutions.

A. Set the Stage

Provide a clipboard and Mediation forms.

1. Two mediators work together; one asks questions, while the other enforces agreement and writes the report.
2. Introduce selves and explain *mediation* offers to help solve a problem. Explain this is a no-lose method.
3. Ask disputants each to make the following agreements.
   a) Agree to solve the problem
   b) No name calling
   c) No interrupting
   d) Be honest
   e) No physical fighting
   f) Speak directly to mediators, not to each other

B. Define the Problem

1. Decide which student will talk first (alphabetically).
   Ask #1 – What happened? Restate
   Ask #1 – How do you feel and why? Restate
   "I feel _____ when _____ because _____."
   Ask #2 – What happened? Restate
   Ask #2 – How do you feel and why? Restate
   "I feel _____ when _____ because _____."
2. Ask any questions that may help the participants understand the problem.

C. Find a Solution

Ask #1 – What can you do to solve the problem?
Ask #2 – What can you do to solve the problem?
List all ideas without comment or judgment.

D. Evaluate the Solution

Read the list and decide which proposed solutions might work.

E. Choose a Solution

Ask #1 – What solution(s) do you think might work?
Ask #2 – What solution(s) do you think might work?
Help disputants find a solution agreeable to both.
Restate the chosen solution or combination of solutions.
Ask #1 – Will you agree to this solution?
Ask #2 – Will you agree to this solution?

F. Plan for Action

1. Decide who needs to do what.
2. Explain the need to trust that each will follow the agreement.
3. Ask each participant to tell their friends that their conflict has been resolved so that rumors can be prevented.
4. Congratulate each of them for their resolution.

G. Check Back for Results

1. Let mediators know how things are going.
2. If a problem reoccurs, let the mediators know.
3. Complete and file the conflict mediator report forms.

AGREEMENTS

AGREE TO TRY TO SOLVE THE PROBLEM

NO NAME CALLING

NO INTERRUPTING

BE HONEST

NO PHYSICAL FIGHTING

SPEAK DIRECTLY TO MEDIATORS

"I" MESSAGE

I FEEL . . . . . .

WHEN YOU . . . . . .

BECAUSE I . . . . . .
(your need)

EXAMPLE:

I FEEL really frustrated **WHEN YOU** play the music so loudly **BECAUSE I** need to study.

CONFLICT MANAGER REPORT FORM

Conflict Managers _____ Date _____

_____

Who had the conflict? _____

_____

What kind of conflict? _____ Argument

_____ Flight

_____ Rumor

_____ Other _____

Referred by: _____ Student _____ Administrator

_____ Teacher _____ Aide

_____ Counselor _____ Yourself

What was the conflict about? _____

_____

_____

Was the conflict resolved? _____ Yes _____ No

Resolution:

Student #1 agrees to:

_____

_____

_____

_____

Student #2 agrees to:

_____

_____

_____

_____

MEDIATION PROCEDURE

STEP 1: EACH PERSON FILLS OUT A MEDIATION PROCESS SHEET BY THEMSELVES

STEP 2: SHARE YOUR ANSWERS WITH EACH OTHER

STEP 3: CHOOSE A SOLUTION THAT IS BEST FOR BOTH OF YOU

STEP 4: FILL OUT A CONTRACT, SIGN IT, AND PRESENT IT TO YOUR TEACHER

MEDIATION PROCESS

1. THIS IS THE PROBLEM FROM MY POINT OF VIEW

2. THIS IS THE PROBLEM FROM THE OTHER PERSON'S POINT OF VIEW.

3. THIS IS HOW I WOULD SOLVE THE PROBLEM

4. THIS IS WHAT I AM WILLING TO DO

MEDIATION CONTRACT

1. THIS IS THE SOLUTION WE HAVE CHOSEN

_____

_____

_____

_____

2. WE AGREE TO ABIDE BY THIS CONTRACT

_____

Signature

_____

Signature

RIOT CHECKLIST
Reprinted with permission from SWRL

- ☐ Contact police department.
- ☐ Ensure safety of students and staff members.
- ☐ Notify families if appropriate.
- ☐ Work with media to defuse the impact of the riot.

Postriot – when the danger is over:

- ☐ If serious injury or death to students or staff, follow Procedures for General Crisis Intervention on page 18.
- ☐ If no serious injury or death to students or staff and school is profoundly affected by riots, convene CRT to:
  - ☐ Identify students who need support;
  - ☐ Assess the need for additional community resource people; and
  - ☐ Develop and distribute discussion questions for teachers.
- ☐ Schedule staff meeting.
- ☐ Hold staff meeting to debrief, provide accurate information, update on vulnerable students, and provide an opportunity to process feelings.

Physical and Sexual Abuse Counseling

Physical and Sexual Abuse Crisis Counseling

What Does the Counselor Do?

What does the Counselor do when there has been physical or sexual abuse? The following points will serve as guidelines when you are confronted with this situation.

- Get all the facts.
- Care for the safety of the client. Arrange for a safe place if they have not made those arrangements or if they cannot.
- Because their normal coping skills are not functioning, you may have to move ahead, whether or not you have their permission.
- Report to the police agency and/or child protective agency.
- Reaffirm your client's strengths.
- Set concrete immediate goals for your client. Develop short term goals that require accountability.
- When necessary, make further referrals to the proper domestic violence agency, sexual assault agency, or other community agencies dealing with physical and sexual abuse.
- Handle outsiders courteously!!! These can include the police, media, parents (of your client or other students' parents), friends, neighbors, and students.
- Sometimes professionals view a person as having a victim mentality. When viewed in this way, the counselor may not address the reasons for the behavior. In the case of sexual abuse, the

abuse never gets addressed, so the client's victim mentality remains unchanged.

Personality Disorders

A predisposition toward the following personality disorders may become evident in persons sexually abused as children: Diagnostic and statistical Manual IIIR, 3rd ed. pp. 347, 349, 353, 354, 232.

HISTRIONIC PERSONALITY DISORDER

A person with histrionic personality disorder constantly seeks reassurance or approval, is inappropriately seductive, preoccupied with appearance, demonstrates exaggerated or shallow emotional expression, constantly seeks to be the center of attention, and has no tolerance for frustration.

BORDERLINE PERSONALITY DISORDER

One with a borderline personality disorder is impulsive in a manner that is self-damaging in life areas such as sex, spending, drug use, and shopping. They display a pattern of unstable and intense interpersonal relationships and often show inappropriate intense anger or lack of control of their temper. They have identity disturbances and show uncertainty about their self-image, gender identity, goals, etc., and exhibit marked shifts in mood – from normal to depressed to irritable. They cannot tolerate being alone and often indulge in self-mutilation or suicide attempts. This state is also characterized by a chronic sense of emptiness.

AVOIDANT PERSONALITY DISORDER

Easily hurt when criticized, the person with an avoidant personality disorder has few friends or perhaps one close friend, does not get involved with others without the certainty of being accepted, avoids

situations where embarrassment or appearing foolish might be possible, and exaggerates the dangers in everyday tasks or situations.

DEPENDENT PERSONALITY DISORDER
An individual with a dependent personality disorder is characterized by the inability to make routine decisions without excessive reassurance, lets others make major decisions for her or him, agrees to do distasteful tasks, and agrees with people in order not to be rejected. They are uncomfortable being alone and avoid being alone, are preoccupied with abandonment, and easily hurt by disapproval.

The diagnostic categories most often used when treating sexual abuse victims are these.

DYSTHYMIA A chronic depressed mood for most of the previous two years that includes over- or undereating, difficulty in sleeping or oversleeping, low energy, poor sense of self-worth, difficulty concentrating or making choices, and a sense of hopelessness. It has been found that 60 percent of those suffering from it may have symptoms of a major depression, which is even more severe than dysthymia.

POST-TRAUMATIC STRESS DISORDER
Recurrent, intrusive, and distressing thoughts or dreams of the abuse, flashbacks, intense distress when in the presence of situations that remind the victim of the abuse characterize post-traumatic stress disorder. The person tries to avoid the thoughts, feelings, or situations similar to those associated with the abuse. They are unable to recall important aspects of the abusive events and show a sense of detachment from others, restricted expression of emotions, sleep disturbances, outbursts, an exaggerated startle response, and overly vigilant for signs of danger.

When talking with a client, Mic Hunter, author of ***Abused Boys: The Neglected Victims of Sexual Abuse,*** offers several helpful suggestions. (Fawcett Columbia Book published by Ballantine Books, 1990, New York, ISBN: 0-449-90629, page 74). The following statements help the victim identify his or her thoughts.

The Counselor says, "*Complete the following sentence with the first thing that comes into your awareness.*

The world is . . .

After writing down the response or having the counselee write it down, the counselor then continues to give him or her these statements to complete.

Men are . . .

Men never . . .

Men always . . .

Women are . . .

Women never . . .

Women always . . .

Because of my past . . .

If only . . .

I always . . .

I never . . .

My thoughts . . .

My body . . .

My emotions . . .

Then the counselor asks the counselee to look over his or her responses and asks, *What do they tell you about yourself and your view of the world?"*

Based on the answer given to this question and the responses to the unfinished statements, the counselor can then offer counseling that is tuned to the mindset of the counselee.

References

Bass, E., & Davis, L. (1988). The Courage to Heal. New York: Harper & Row.

Bass, E., & Thornton, L. (1983). I Never Told Anyone. New York: Harper & Row.

Finklehor, D. (1984). Child Sexual Abuse. New York: Free Press.

Gilliland, Burl E. & James, Richard K. (1988). Crisis Intervention Strategies. Brooks/Cole Publishing Co., Pacific Grove, California.

Herman, J. (1981). Father/Daughter Incest. Cambridge, MA; Harvard University Press.

Hindman, J. (1989). Just Before Dawn. Ontario, OR: Alexandria Associates.

Hunter, Mic. (1990). Abused Boys: The Neglected Victims of Sexual Abuse. Fawcett Columbine Book - Ballantine Books, New York.

Long, S. (1986) Guidelines for treating young children. In K. MacFarlane & J Waterman (eds.), Sexual Abuse of Young Children. New York: Guilford Press.

Miller, R., Johnson, J.A., & Johnson, J. K. (1991). Assessing the prevalence of unwanted childhood sexual experiences. Journal of Psychology and Human Sexuality, 4.

Rencken, R. (1989). Intervention Strategies for Sexual Abuse. Alexandria, VA: American Association for Counseling and Development.

Russell D. (1983) Incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. Child Abuse and Neglect.

Tennant, C. G. (1988) Preventive sexual abuse programs; Problems and possibilities. Elementary School Guidance and Counseling, 23.

Date Rape

Ms. Magazine Survey Statistics

1 in 4 women surveyed were victims of rape or attempted rape.

84 percent of those raped knew their attacker.

57 percent of the rapes happened on dates.

Myths About Date Rape

- Rape is committed by crazed strangers.
- A woman who gets raped deserves it, especially if she agrees to go the man's house or ride in his car.
- Women who do not fight back have not been raped.
- If there is no gun or knife, you have not been raped.
- It is not really rape if the victim is not a virgin.
- If a woman lets a man buy her dinner or pay for a movie or drinks, she owes him sex.
- Agreeing to kiss or neck or pet with a man means a woman has agreed to have intercourse with him.
- When men are sexually aroused, they need to have sex or they will get *blue balls*.
- Once they get turned on, men cannot help themselves from forcing sex on a woman.
- Women lie about being raped, especially when they accuse men they date or other acquaintances.

Aftereffects of Date Rape

A. Emotional consequences
B. Physical consequences: injury, pregnancy, and abortion
C. Sexual consequences
D. Consequences of telling boyfriends, husbands, or fathers
E. Aftereffects on friendships and family relations
F. Confronting the rapist and other post-rape fantasies
G. The long road to recovery

Recommended Program for Campuses

1. Develop a written policy condemning rape and other sexual assaults and emphasizing that these crimes will not be tolerated on campus. The policy statement should focus on acquaintance rape, which is particularly prevalent, and copies of the statement sent to every student.
2. Revise the code of student conduct to specifically prohibit rape and other sexual assaults on campus.
3. Include specific rights for victims in student codes, such as the right to have someone accompany the victim throughout the disciplinary process; the right not to have irrelevant past sexual history discussed; and the right to deliver a victim impact statement or suggest an appropriate penalty if the accused rapist is found to have violated the code of student conduct.
4. Establish an immediate hearing procedure or informal method to modify living arrangements in cases where the victim and the accused live in the same dormitory or housing complex.

5. Institute comprehensive campus-wide educational programs on sexual assault to inform students, faculty, and staff of its frequency and to teach preventive strategies.
6. Establish an effective program to assist the victims of sexual assaults. The program should include:
   a) Written protocols describing exactly how the staff should respond to these cases.
   b) Immediate medical treatment.
   c) Referral to free, trained therapists.
   d) The services of a campus-sponsored Victim Advocate.
   e) A brochure informing victims about sexual assaults and available options.
   f) Extensive training for all personnel who may interact with sexual assault victims.
   g) Procedures for coordination with local police agencies in responding to assaults.
7. Adopt procedures that will encourage victims to report sexual assaults to the staff and facilitate gathering the crucial information about these assaults.
8. Disseminate detailed information regarding campus crimes so that students, faculty, and staff will know how and when sexual assaults are likely to occur. They can then be prepared to take appropriate preventive steps.
9. Implement security measures that will reduce the likelihood of sexual assaults, such as increased lighting, safe landscaping patterns, effective dormitory security devices, self-locking doors on residents' room and evening escort services.
10. Establish a task force of students, faculty, and staff that will be responsible for reviewing crimes on campus, implementing ways to prevent dangerous situations, and providing appropriate care for victims.

RAPE RESPONSE CHECKLIST
Reprinted from SWRL

- ☐ School involvement in incident is due to:
  - ☐ Rape occurrence on campus;
  - ☐ Survivor's family requests school intervention;
  - ☐ Survivor's friends request intervention;
  - ☐ Rumors and myths are widespread and damaging; and/or
  - ☐ Students witness police action/emergency services.
- ☐ Information provider/recipients enjoined not to repeat information elsewhere.
- ☐ Steps taken to protect survivor's identity and right to privacy.
- ☐ Law enforcement and rape crisis agency notified if appropriate.
- ☐ CRT member closest to victim designated to talk with student and determine type of support and support provider desired.
- ☐ Rape survivor encouraged to seek additional support from community rape crisis agency.
- ☐ Space provided on site for rape survivor and identified peers to receive support services.
- ☐ School services coordinated as appropriate and legal with outside service providers.
- ☐ Action taken to quell rumors.
- ☐ All records related to rape incident and services provided stored in confidential file.

Domestic Violence

Causes

- Stress situations, such as loss of a job, financial problems, pregnancy, or role changes
- Frustrations
- Alcohol and/or drug abuse
- Abuse-prone attitudes and beliefs: a) show the woman who's boss; b) a little slap is good for her; or c) he wouldn't hit me if I didn't deserve it.
- Sadistic personality
- Childhood experiences of abuse and/or parental violence
- Mental or physical disorders
- Need for power and control in relationships

The following information was taken from an in-depth research paper completed by Sr. Clare Lord.

Domestic violence is defined to include all forms of violent behavior between people who live together. It includes a husband who beats his wife; a wife who beats her husband; an unmarried person living with a person of the opposite sex or of the same sex in an intimate relationship who beats the other person; and a parent, guardian, or other family member who sexually assaults or physically abuses his or her child.

Some Causes of Domestic Violence

- Stress
- Frustrations
- Alcohol
- Abuse-prone attitudes
- Sadistic personality
- Childhood experiences of abuse or domestic violence
- Mental and physical disorders
- Need for power and control in relationships

Common Similarities (found within different battering situations)

- Initial surprise
- Unpredictability of acute battering incidents
- Overwhelming jealousy
- Unusual sexuality
- Lucid recall of battering incidents
- Concealment
- Drinking
- Extreme psychological abuse (verbal and brainwashing techniques)
- Family threats
- Extraordinary terror (through the use of guns and knives)
- Omnipotence
- Awareness of death potential

Why Does It Happen?

- Attitude of society – What happens in the home is *a private affair."*
- Force – believed to be the only way to *effectively* communicate.
- Stress factor

Types of Abuse

- Physical abuse and sexual abuse
- Economic deprivation
- Family discord
- Family discord – child abuse
- Social battering

Domestic Violence Statistics

- A domestic violence-related killing occurs somewhere in this country every six hours.
- These killings account for almost one-third of the women who are murdered.
- At least two-thirds of the 56 million married and cohabiting couples in this country have experienced at least one violent incident.
- 182,540 domestic violence calls were received by California law enforcement agencies in 1988.
- Women are the victims in 90 percent of the assaults and two-thirds of the domestic murders recorded by the U. S. Justice Department.
- Battering is this nation's largest cause of injury to women, according to the Surgeon General in 1984.
- California law, since 1985, requires that all police officers receive 8½ hours of domestic violence training.
- Suspects who are arrested are only half as likely to repeat the offense as those who are counseled or taken away from the scene.
- Restraining orders work well in 80 to 90 percent of the cases. In the other cases, they are useless.
- San Diego has the most aggressive prosecution effort in California. 1,400 misdemeanor spousal abuse cases go to court each year; about 80 percent of those involve victims who do not want to prosecute.
- A 1988 San Diego study showed that of 200 misdemeanor abusers who were sentenced to one year of weekly counseling sessions, 72 percent completed the counseling. Of those, none were arrested again within the next year. Nearly half of those who dropped out were arrested again for spousal abuse.

Warning Signs of Abuse

The Abusive Parent

- Presents a contradictory history of injuries and is reluctant to give detailed information on the child's injuries
- Delays medical treatment and refuses to consent to further diagnostic testing
- Has poor impulse control
- Is socially isolated and untrusting or suspicious of people
- Reacts inappropriately to child's needs; may under- or overreact; has unrealistic expectations of child's behavior
- Presents a history of family discord or personal problems such as abuse or neglect as a child, alcohol abuse or abuse of other substances, and psychopathology

The Abused Woman

- Shows guilt, ambivalence, and fear of living conditions
- Feels isolated and untrusting of others, although she may be very involved in the neighborhood and community
- Is emotionally dependent as well as financially dependent
- Has low self-esteem and coping skills
- Has observed other women in the family being abused and may have been abused as a child
- Feels angry, embarrassed, and ashamed
- Is fearful for no apparent reason
- Has accommodated to feeling helpless and powerless

The Abusive Man

- Is extremely jealous and will isolate children and women
- Has poor coping and impulse control, although this may not necessarily appear outside the home
- Has poor self-image and projects. Experiences severe mood swings
- May have a history of abuse in his own family or during courtship.
- Accepts violence as a coping/problem-solving technique
- Presents a history of personal discord, unemployment, cruelty to animals, alcohol or drug abuse, and/or psychopathology

DomesticViolence

Battering (Abuse) =

The use of physical force or the threat of physical force to control and maintain power over someone. It involves frightening and intimidating someone repeatedly over a period of time.

A Battered Woman =

A victim of repeated physical and emotional abuse by a husband, ex-husband, lover, or boyfriend who is jealous and controlling.

A Battered Man =

Battering always becomes more frequent and severe over time – unless something is done to stop it.

The Cycle of Violence
Adapted from Lenore Walker

Battering usually starts *after* a wedding or moving in together – often during a pregnancy. In the beginning, battering incidents may be brief and relatively mild and far apart. A woman may find it very difficult to give up all her hopes and expectations and end the relationship, so she finds it easy to believe her mate's promises to change. Over time, the beatings become more severe and occur closer together. Batterers become more skilled in battering and gain more control. They inflict the most hurt and fear with the least outward signs. As time passes, it becomes more difficult to leave him because the woman becomes more fearful and dependent as children arrive. Her self-esteem drops, and she becomes more and more isolated. Eventually the *honeymoon* phase disappears and the cycle goes from tension building to battering and back again. Either parent may begin to abuse the children or neglect them, and they are always affected emotionally.

Cycle of Violence – Three Phases

1. **Tension Building Phase** (preceding battering incident)
2. **Acute Battering Phase** (actual battering incident)
3. **Calm Respite Phase (Honeymoon Phase)** (preceding battering incident)

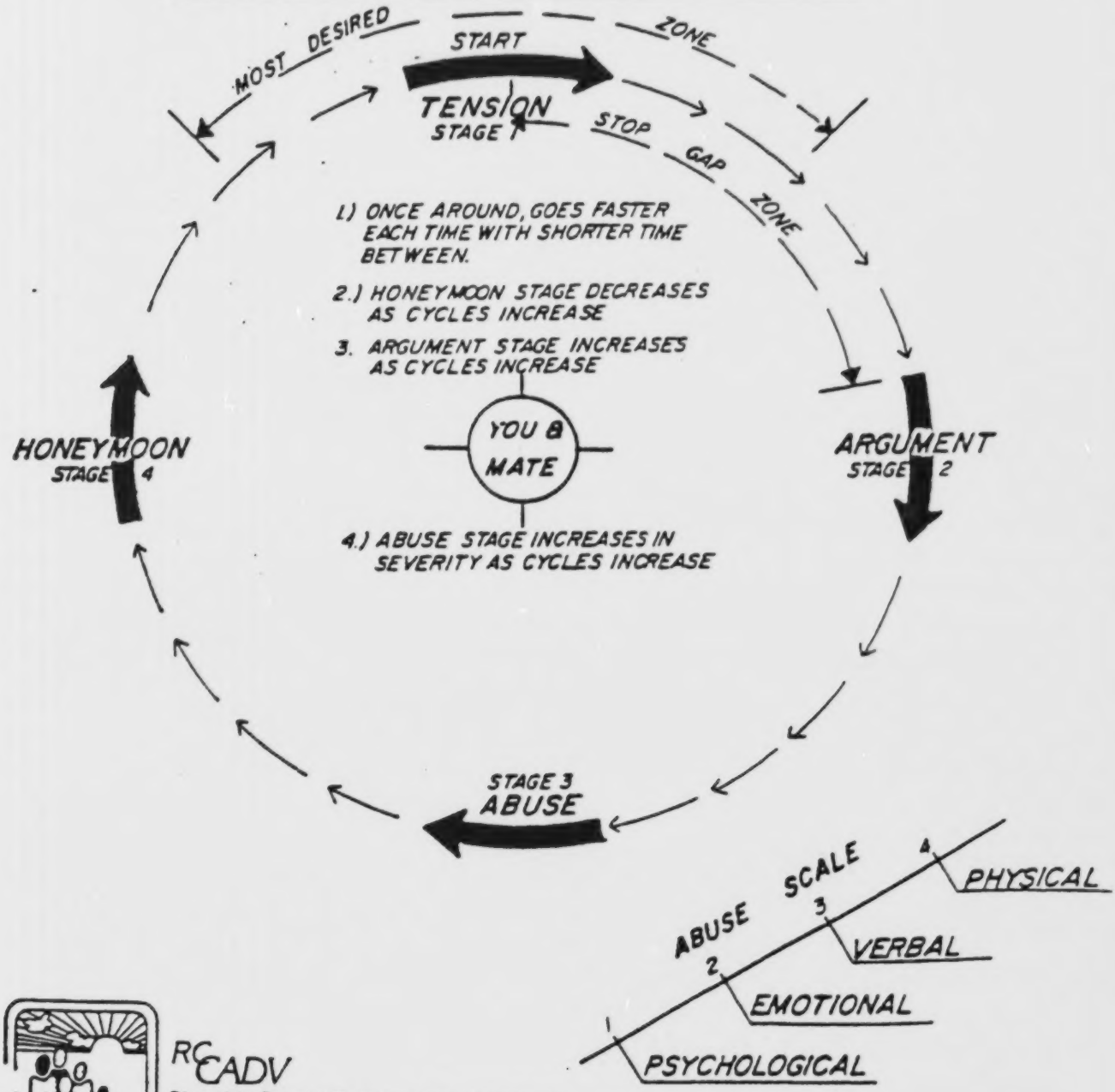
Increasing spiral of violence – Once the violence has begun, it increases in both frequency and severity, and the length of the phases changes.

Tension Building: Verbal and emotional abuse begins again. Espionage tactics become more pronounced. The batterer targets pent-up anger and frustrations at the woman and possibly the children. She may try exceedingly hard to please him and walk on eggs. Eventually, she may feel like a failure. Even her best effort was not good enough. She may also believe she provoked him. Either way, women often feel responsible for the violence against them. People may ask her, "What did you do to make him hit you?" or "Why don't you just leave?"

Acute Battering Incident: The tension-building phase explodes into violence. Battering may include verbal abuse, threats, rape and other sexual abuse, intimidation, humiliation, and other forms of abuse as well as a wide range of physical violence.

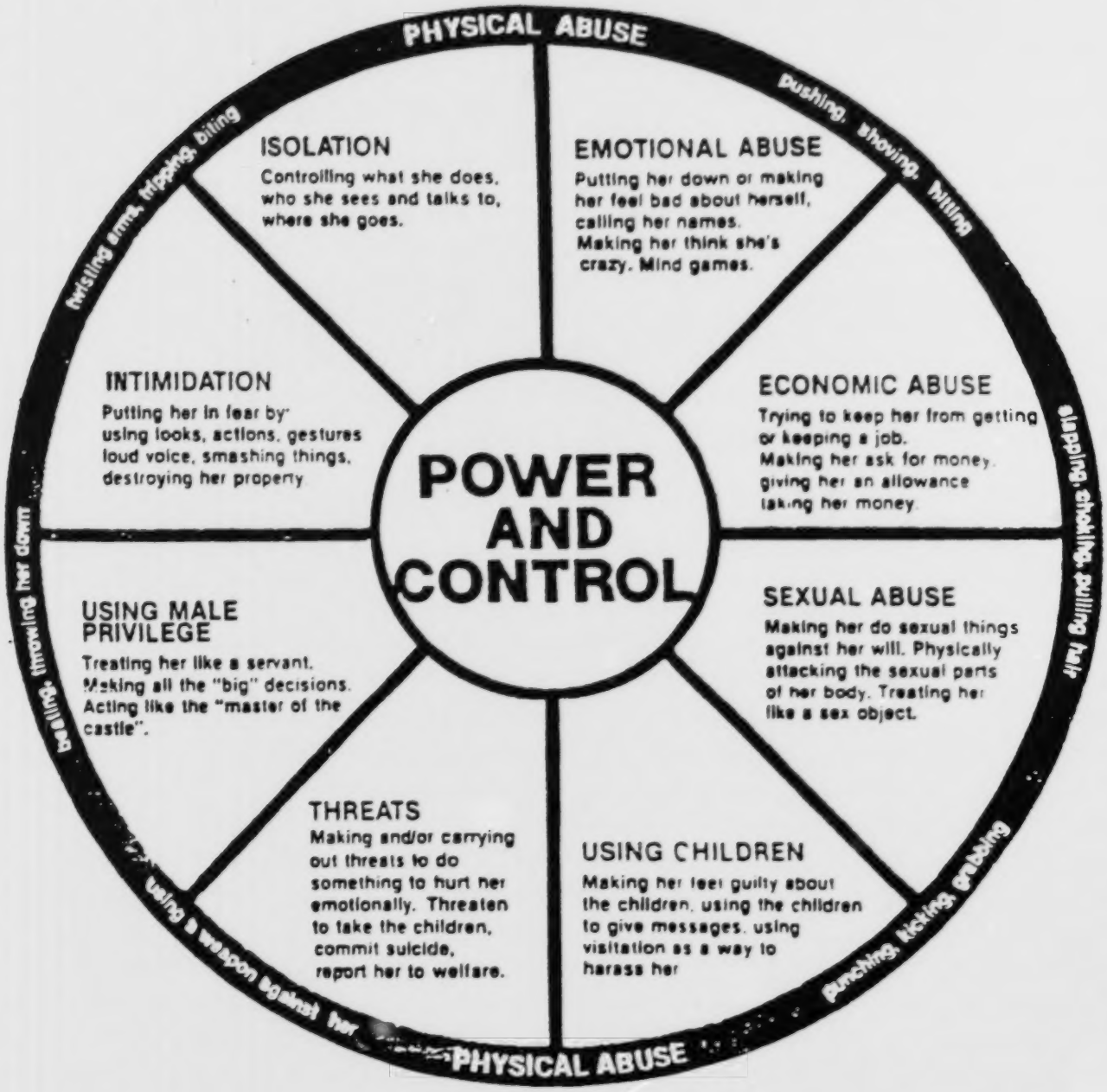
Loving Respite: At first, the woman may be too frightened or hurt to seek help. Also, she knows she will be safe for a while. The batterer makes promises to change and says things will improve. He is very loving, attentive, and very needy. The woman may have some power to gain temporary concessions from him and sees them as positive signs. He begins to shift the blame for the incident to her and/or deny the battering took place. He may even minimize its severity.

VIOLENCE CYCLE



"Horizon House"
RCEADV
Riverside County Coalition for Alternatives to Domestic Violence
P.O. Box 910, Riverside, California 92502
684-1720

BEST COPY AVAILABLE


PHYSICAL ABUSE
Pushing, shoving, hitting
slapping, shaking, pulling hair
punching, kicking, grabbing
using a weapon against her
PHYSICAL ABUSE
beating, throwing her down
twisting arms, tripping, biting
POWER AND CONTROL
ISOLATION
Controlling what she does, who she sees and talks to, where she goes.
EMOTIONAL ABUSE
Putting her down or making her feel bad about herself, calling her names. Making her think she's crazy. Mind games.
INTIMIDATION
Putting her in fear by using looks, actions, gestures loud voice, smashing things, destroying her property
ECONOMIC ABUSE
Trying to keep her from getting or keeping a job. Making her ask for money, giving her an allowance taking her money.
USING MALE PRIVILEGE
Treating her like a servant. Making all the "big" decisions. Acting like the "master of the castle".
SEXUAL ABUSE
Making her do sexual things against her will. Physically attacking the sexual parts of her body. Treating her like a sex object.
THREATS
Making and/or carrying out threats to do something to hurt her emotionally. Threaten to take the children, commit suicide, report her to welfare.
USING CHILDREN
Making her feel guilty about the children, using the children to give messages, using visitation as a way to harass her

BEST COPY AVAILABLE

Common Characteristics of a Male Batterer

1. Was abused as a child, or saw his father abuse his mother
2. Has a low opinion of women
3. Has a love/hate relationship with his mother
4. Is jealous and possessive
5. Drinks or uses drugs excessively at times
6. Is demanding of his mate's time and attention
7. Is *Macho* acting
8. Is critical and difficult to please
9. Treats his mate like a possession
10. Has a quick, explosive temper
11. Is overly suspicious and accusing
12. Blames others
13. Is unreasonable and inflexible at times
14. Is easily annoyed or threatened
15. Encourages his mate's dependence
16. Is preoccupied with violence, guns, knives, etc.
17. Is boastful and arrogant
18. Feels no one understands him
19. Is impulsive
20. Uses aggressive sex to demonstrate superiority and control
21. Is loving and kind at times
22. Is remorseful after the violence
23. Is a good provider
24. Is a *Yes* guy outside the home on the job and is socially charming

Common Characteristics of the Female Victim

1. Had traditional role-modeling
2. Was raised to measure her success as a human being with her success as a wife and mother
3. Is financially dependent on her spouse
4. Has few friends and minimal family contact
5. Has strong feeling of worthlessness and aloneness
6. Is fearful for her life and the lives of her children
7. Often believes she is the cause of the abuse
8. Is uninformed about resources for help
9. Feels ashamed of the abuse
10. Survives on the hope for a change in the relationship
11. Has seen her own mother abused by her father
12. Sometimes confuses love and violence
13. Knows that the threat to her life may actually increase if she leaves
14. Is fearful that her spouse will take her children from her
15. Feels that it is her job to hold the family together
16. Sees her husband's happiness as a measure of her success as a wife
17. Knows that leaving her spouse will mean tremendous economic, emotional, occupational, and personal hardships
18. Commonly uses denial as a coping mechanism
19. Believes that she cannot survive without him and no on else could love her
20. Suffers from guilt, yet denies the terror she feels
21. Uses sex as a way to establish intimacy

Myths About Battered Women

Myth #1: The battered woman syndrome affects only a small percentage of the population.

Myth #2: Battered women are masochistic.

Myth #3: Battered women are crazy.

Myth #4: Middle-class women do not get battered as frequently or as violently as do poorer women.

Myth #5: Minority-group women are battered more frequently than Anglos.

Myth #6: Religious beliefs will prevent battering.

Myth #7: Battered women are uneducated and have few job skills.

Myth #8: Batterers are violent in all their relationships.

Myth #9: Batterers are unsuccessful and lack resources to cope with the world.

Myth #10: Drinking causes battering behavior.

Myth #11: Batterers are psychopathic personalities.

Myth #12: Police can protect the battered women.

Myth #13: The batterer is not a loving parent.

Myth #14: A wife batterer also beats his children.

Myth #15: Once a batterer, always a batterer.

Myth #16: Once a battered woman, always a battered woman.

Myth #17: Long-standing battering relationships can change for the better.

Myth #18: Battered women deserve to get beaten.

Myth #19: Battered women can always leave home.

Myth #20: Batterers will cease their violence *when we get married.*

Myth #21: Children need their father even if he is violent – or the mother says, "I'm only staying for the sake of the children."

Why Does the Battered Woman Stay?

1. Loneliness.
2. She does not want to leave her children.
3. She has no place to go.
4. She lacks financial resources and employment skills.
5. She hopes her husband or partner will change.
6. She does not know where, or how, to seek help.
7. She fears reprisals from her husband or partner. She is afraid of what the man will do to her and the children if she tries to leave him.
8. She is afraid to live without a man.
9. She believes children need a father *and* a mother.
10. She considers divorce a stigma; she believe she has to keep her husband and family together at all costs, despite the pain and danger.
11. She loves her husband or partner.
12. She knows it is difficult for women with school-age children to find work.
13. She believes it is shameful for women to admit they do not have good marriages.
14. She considers her husband or partner a victim and wants to help him.
15. She is blamed by society for her own victimization.
16. She believes she is at fault, and she has no worth as a person.
17. Because the police, lawyers, courts, mental health professionals, clergy, friends, medical personnel, family members, and the law itself all provide tacit approval of wife beating, she thinks she must stay.

Legal Procedures for Abused Women

The victim should:

1. **Call the Police:** They are required in California and some other states not only to come to the residence, but they also must file a report. Get a copy of the report.
2. **Insist on Arrest:** The police must arrest if they feel a crime may have been committed, even if it was not in their presence. If the police have doubts, a citizen's arrest can be made, and the police will then have to act on this action.
3. **Courts:** File immediately for an order to show cause for support as well as for temporary custody of the children of the marriage.
4. **Restraining Orders:** File for either a temporary restraining order (TRO) – good for 30 days – or for a *kick out* order for personal protection.
5. **Court Hearing Day:** Bring witnesses and evidence.
6. **Reinforcing the Order of Protection:** If a TRO has been obtained, there are ways of enforcing it through the police.

Bibliography

Adams, Aileen and Abarbanel, Gail. (August, 1988). Sexual Assault on Campus: What Colleges Can Do. Rape Treatment Center, Santa Monica, CA: Rape Treatment Center.

Adams, Caren, Fay, Jennifer, and Lorren-Martin, Jan. (1984). NO is Not Enough: Helping Teenagers Avoid Sexual Assault. Impact Publishers: San Luis Obispo, California.

Bean, Barbara and Bennett, Shari. (1993). The Me Nobody Knows: A Guide for Teen Survivors. Lexington Books: New York.

Domestic Violence Handbook: A Victim's Guide. (June, 1988) Crime Prevention Center, Office of the Attorney General, P O Box 944255, Sacramento, CA 942440-2550.

Mc Shane, Claudette. (1988) Warning! Dating May be Hazardous to Your Health. Mother Courage Press: Racine, WI 53405.

Warshaw, Robin. (1988) I Never Called It RAPE: The Ms. Report on Recognizing, Fighting, and Surviving Date and Acquaintance Rape. Harper Perennial: New York.

Videos

"Playing the Game." A Healthvisions Production by Robin Sawyer, Ph.D. Contains discussion guide and peer program protocol.

"Campus Rape." Rape Treatment Center, Santa Monica Hospital Medical Center. Contains discussion guide, facilitator tips, and prevention plans.

Natural & Physical

Disasters

Natural & Physical Disasters

Natural Disasters

Disasters caused by natural forces, or what insurance companies call *acts of God* – floods, earthquakes, tornadoes, hurricanes, etc., can affect large areas and thousands of people. This places a strain on a community's resources for responding to a crisis. Physical disasters such as fires, explosions, hazardous chemical spills and war may have the same effect on a community's ability to respond.

In fact, one of the reasons this handbook was developed was the recognition by CACD that some community resources may be inadequate to meet the need for crisis counseling. Following certain traumatic occurrences, there could be a group of trained persons, either employed or retired, who can provide additional crisis counseling intervention services.

A unique characteristic of natural and physical disasters, is that the crisis intervention counselor is often also a *victim* of the same event. The dual role usually results from the widespread effects of this type of crisis event. This victim/counselor role is unique because in crisis events such as homicide, violence, physical and sexual abuse, or death, the victim is ordinarily counseled by a person who has not been affected by that same crisis. In some cases, however, the counselor may have previously experienced a similar crisis.

Therefore, in natural and physical disasters, it is important for crisis counselors to set aside time to debrief and talk about their own feelings and emotions regarding the disaster with their colleagues. They should also include how they feel about the possibility of recovery from the event.

In a study of mental health workers who assisted in the aftermath of Hurricane Hugo in 1989, researchers (Muzeraki, 1991) discovered there was a discrepancy between the counselors' perception of themselves and their co-workers. ***Most counselors saw themselves as being less impacted than their co- workers.***

The researchers also found there were residual effects for as long as a year, and the reactions of these workers paralleled the *grieving process*. Crisis counselors in this situation progressed in an orderly fashion from disbelief, powerlessness, sadness, fear, anger, and confusion to hopefulness, and satisfaction: stages that people in grief experience.

Consequently, in disaster planning, it is important for an organization to establish a time for crisis counselors and other support workers **to debrief** as a routine part of their crisis plan.

During these debriefing sessions, each person needs to be allotted time to *tell* their story or *share* their experiences in a small group setting. This allows crisis counselors the opportunity to begin the healing process for themselves as well as helping others to heal. Crisis counselors and support personnel are not immune from personal reactions to the disaster. Care for the caregivers needs to be planned so they are able to adequately serve the other victims.

Assessment

Assessment is important in all crisis events, but natural or physical disasters (or situations where a crisis event may affect a large number of persons) need an additional phase, **a triage system**. Triage is a process of establishing a priority system for the treatment of victims according to the severity of the person's crisis state. A useful tool for this process is the *Triage Assessment Form* included in **Introduction to Crisis Intervention: Other Resources** (pp. 32-34).

Post-traumatic Stress Disorder

Everyone reacts to a crisis, and it is this reaction that is assessed to determine what type of assistance or psychological first aid is needed for the person to deal with the crisis effectively. This reaction is evaluated in terms of how appropriate it is in light of the crisis and to what extent this reaction interferes with the person's normal routine of daily functioning.

Karl A. Slaikeu in his book, ***Crisis Intervention: A Handbook for Practice and Research,*** as well as Burl E. Gilliland and Richard K. James in their book, ***Crisis Intervention Strategies,*** point out that crisis intervention is very effective in preventing debilitating effects following a crisis event. This is especially true after a natural or physical disaster because so many people are involved.

They point out that while some symptoms may last up to a year, crisis intervention counseling, when provided in a timely manner, is nonetheless effective in assisting people to cope with their stress. This assistance frequently prevents the onset of **Post-traumatic Stress Disorder (PTSD)**.

While any catastrophe brings trauma to those who experience it, those crisis events that directly affect the social support system of the family are more apt to result in a Post-traumatic Stress Disorder in victims. Victims of crisis events such as children of murdered parents, hostages, raped women, and victims of incest are especially vulnerable to the onset of Post-traumatic Stress Disorder.

The ***Diagnostic and Statistical Manual of Mental Disorders,*** published by the American Psychiatric Assn., outlines the symptoms of PTSD.

The central feature of this disorder is that symptoms develop following a *psychologically distressing event* that is outside the normal human experience. Simple bereavement, chronic illness, business losses, or marital conflicts are not

classified as psychologically distressing events. The most common symptoms of PTSD are:

- Experiencing the traumatic event again (perhaps many times)
- Avoiding any stimuli associated with the traumatic event
- Numbing of general responsiveness
- Increased arousal

The diagnosis of Post-traumatic Stress Disorder is not made unless the symptoms are present for longer than one month.

Reexperiencing the traumatic event or crisis must take at least one of the following patterns before it can be diagnosed as PTSD.

- There are usually recurring memories, which are intrusive and intrude upon one's consciousness uncontrollably. In children, there is often repetitive play in which the themes or aspects of the trauma are expressed.
- Especially in children, there may be distressing dreams in which the person reexperiences the crisis.
- A person may experience a sudden feeling as though the traumatic event were recurring. This feeling may include flashbacks, illusions, or hallucinations (even those that occur upon reawakening or when the person is intoxicated).
- There is extreme psychological distress when the person is exposed to events that symbolize or resemble an aspect of the traumatic event.

A second characteristic of PTSD is the persistent **avoidance** of stimuli associated with the trauma or a **numbing**

of overall responsiveness. This is considered as being present when at least three of the following patterns of behavior occur.

- The person attempts to avoid the thoughts and feelings that are associated with the trauma.
- The person makes an effort to avoid activities or situations that arouse memories of the crisis.
- A person is unable to recall an important aspect of the crisis.
- A person exhibits a marked loss of interest in significant activities.
- In children, this takes the form of the loss of recently learned developmental skills such as toilet training or language skills.
- A person develops a feeling of attachment for or estrangement from others.
- A person develops a restricted range of affection or is unable to have love feelings).
- A person experiences a foreshortened future, (i.e., does not expect to have a career, marriage, long life, or children.)

A third characteristic of PTSD is exhibiting persistent symptoms of **increased arousal** that were not present prior to the crisis event. The persistent symptoms are characterized by at least two of the following behavior patterns:

- Sleep disturbances (difficulty in falling or staying asleep)
- Outbursts of anger following the person's inability to perform to his or her satisfaction
- Difficulty in concentrating
- Hypervigilance
- Exaggerated startle response
- Physiological reactions (sweating, trouble breathing etc.) upon exposure to events that symbolize or resemble an aspect of the traumatic event

While persons who have experienced a traumatic event or crisis may experience these symptoms and other anxietal reactions, it is not considered a disorder unless the above occur for longer than a month. Symptoms usually begin immediately

or very soon after the crisis, although reexperiencing symptoms may not develop until after a latency period of months or years.

According to Gilliland and James, the best treatment strategies for children who are diagnosed as having Post-traumatic Stress Disorder are the reenactment of the trauma through the use of guided imagery, play therapy, sand play, writing, music, drama, drawing, and telling a story about it. They further recommend that therapeutic intervention should be referred to a specialist in child therapy.

For further information regarding PTSD consult:

1. The ***Diagnostic and Statistical Manual of the Mental Disorders*** published by the American Psychiatric Assn.
2. Burl E. Gilliland and Richard K. James, ***Crisis Intervention Strategies*** Brooks/Cole Publishing Co. Pacific Grove, California, 1993.

Resources

Project Cope	Peter Spofford, Director Connie Grimes, Coordinator, School Services
Project Rebound	Los Angeles County Department of Mental Health 2415 West Sixth Street Los Angeles, CA 90057 **Crisis Hotline (800) 854-7771**
FEMA	Earthquake Education Program 500 C Street, SW (Rm. 625) Washington, DC 20472

Bibliography

How to Help Children After a Disaster. Alameda County Mental Health Services, California. Also available from Project Rebound.

Diagnostic and Statistical Manual of Mental Disorders (Third Edition, Revised). American Psychiatric Association, Washington, DC, 1987.

Gelman, David and Katel, Peter. "The Trauma After the Storm," Newsweek Magazine, April 5, 1993.

Gilliland, Burl E. and James, Richard K. Crisis Intervention Strategies. Pacific Grove, CA: Brooks/Cole, 1993.

McCammon, Susan, Parker, Leslie, and Horton, Randy. Community Post-Tornado Support Groups: Intervention and Evaluation. A paper presented to the American Psychological Association, August 23, 1986. Washington, DC.

Muzerkari, Louis H. and Lonigan, Christopher J., Bond, Frank K., and Hiers, Thomas G. In the Eye of the Beholder: Charleston Mental Health Center Reactions to Disaster. A paper presented to the annual convention of the American Psychological Association. San Francisco: August, 1991.

Project Cope. Coping With Disaster: A Reference Guide for Teachers, Pre-School Through High School.

Project Cope. School Intervention Following a Critical Incident. Federal Emergency Management Agency, 1991. FEMA 220/November, 1991.

Project Rebound. Helping Children After a Disaster. Los Angeles County Department of Mental Health. Federal Emergency Management Agency (FEMA).

Van Ornun, William and Mordock, John B. Crisis Counseling With Children and Adolescents. New York: Continum, 1984.

Peterson, Sun and Straub, Ron L. School Crisis Survival Guide. West Nyak, NY: The Center for Applied Research in Education, 1992.

Slaikeu, Karl. Crisis Intervention: A Handbook for Practice and Research. Allyn and Bacon: 1984.

Thompson, Rosemary. Suicide and Sudden Loss: Crisis Management in the Schools. Office of Educational Research and Improvement, Washington, DC: ERIC/CAPS Digest: Ann Arbor.

Natural & Physical Disasters

Other Resources

Helping Children After a Disaster

By

Project Rebound
Los Angeles County Department of Mental Health
2415 West 6th Street
Los Angeles, CA 90057

When Do Reactions Occur?

Usually, these reactions occur immediately following the disaster. Sometimes, however, a child will seem to be doing fine immediately following the disaster but then experience a delayed response. It may occur weeks – or even months – later.

Early Childhood: Ages 5 to 11

Regressive behaviors are especially common in this age group. Children may become more withdrawn or more aggressive. They may be particularly affected by the loss of prized objects or pets.

Encourage verbalization and play enactment of their experiences. Resume normal functioning as soon as possible, but temporarily relax routine expectations.

Regressive Reactions

- Increased competition with younger siblings for parental attention
- Excessive clinging
- Crying or whimpering
- Wanting to be fed or dressed
- Engages in habits previously given up
- Drop in level of school achievement

Physiological Reactions

- Headaches
- Complaints of visual or hearing problems
- Persistent itching and scratching
- Crying or whimpering
- Nausea
- Sleep disturbance, including nightmares and night terrors
- Complaints of unexplainable pains

Emotional and Behavioral Reactions

- School Phobia
- Withdrawal from play group and friends
- Hyperactivity
- Withdrawal from family contacts
- Irritability
- Disobedience
- Fear of wind, rain, etc.
- Inability to concentrate
- Aggressive behavior (e.g., fighting with friends and siblings
- Repetitive talking about the experience
- Sadness over loss

Reassuring Responses

- ✓ Give reassurance that the child's competency will return
- ✓ Provide opportunity for structured but not demanding chores and responsibilities
- ✓ Encourage physical activity
- ✓ Give child permission to discuss his or her uneasiness by acknowledging your own fear
- ✓ Provide play session with adults and peers
- ✓ Rehearse safety measures to be taken in future
- ✓ Answer questions about the disaster honesty and simply
- ✓ Avoid giving the child access to graphic television depictions of the event
- ✓ Encourage verbalization of loss, grieving over loss of pets or toys
- ✓ Encourage attempts to integrate experiences

Preadolescent: Ages 11 to 14

Peer reactions are very important to this group. Children need acceptance from their friends and assurance their feelings and fears are normal. Anxiety and tension may be shown through aggression, rebellion, withdrawal, rebellion, withdrawal or attention-seeking behavior. *Survivor's guilt* may be noticeable in children of this age.

Group discussions with peers and adults are effective in reducing the sense of isolation and normalizing the child's feelings. Resumption of group activities and routines and involvement in physical activities may be helpful in reducing tension.

Regressive Reactions

- Competing with younger siblings for parental attention
- Failure to perform chores and normal responsibilities

Physiological Reactions

- Headaches
- Complaints of vague aches
- Overeating or loss of appetite
- Bowel problems
- Skin disorders
- Sleep disorders including sleeping excessively

Emotional/Behavioral Reactions

- Loss of interest in peer activities
- Drop in level of school performance
- Disruptive behavior
- Loss of interest in hobbies and recreation
- Decline in school
- Withdrawal
- Resistance to authority
- Increased difficulty in relating to siblings & parents
- Sadness or depression
- Antisocial behavior (e.g., stealing, lying drug abuse)

Reassuring Responses

- ✓ Give additional consideration and attention
- ✓ Provide reassurance that ability to concentrate will return
- ✓ Reduce expectations temporarily of level of performance at school and home
- ✓ Encourage verbal expression of feelings
- ✓ Provide structured but undemanding responsibilities
- ✓ Encourage taking part in home or community recovery efforts
- ✓ Rehearse safety measures to be taken in future disasters
- ✓ Encourage physical activity
- ✓ Encourage play or contact with friends

Adolescent: Ages 14 to 18

Adolescent activities and interests are primarily focused on the peer group. Fear that feelings or reactions are unusual or unacceptable may push adolescents toward withdrawal or depression. Psychosomatic reactions are common. Adolescents may resent disruption of their social activities and contacts and be frustrated by the inability to assume full adult responsibilities in community efforts. Frustrations, anger, and guilt may be vented in irresponsible, even delinquent, behavior.

Adolescents should be encouraged to maintain contacts with friends and to resume athletic and social activities. Group discussions are helpful in normalizing feelings. Adolescents should be encouraged to participate in community rehabilitation efforts.

Regressive Reactions

- ♦ Resumption of earlier behaviors and attitudes
- ♦ Decline in previous responsible behavior
- ♦ Decline in emancipatory struggles over parental control
- ♦ Decline in social interests and activities

Physiological Reactions

- ♦ Bowel and bladder complaints
- ♦ Skin rash
- ♦ Sleep disorders
- ♦ Digestive disorders
- ♦ Vague physical complaints or exaggerated fears of physical problems
- ♦ Painful menses or cessation of menses in young women
- ♦ Headaches

Emotional/Behavioral Reactions

- Marked increase or decrease in physical activity level
- Delinquent behavior, such as stealing or vandalism
- Increased difficulty in concentration on planned activities
- Isolation or withdrawal from family and peers
- Increased/excessive aggression toward family members or peers
- Denial of negative reactions to the incident

Reassuring Responses

- ✓ Encourage discussion of disaster experiences with peers and significant others
- ✓ Encourage involvement in rehabilitation and recovery efforts in the community
- ✓ Reduce expectations temporarily for level of performance at school and home
- ✓ Encourage resumption of social activities and athletics
- ✓ Encourage healthy outlet of aggressive feelings (including screaming in pillow, pummeling a punching bag, walking and other physical activities)
- ✓ Obtain professional counseling for drug abuse or denial of use

NATURAL DISASTER CHECKLIST

Reprinted with permission from SWRL

- ☐ Designate a meeting place and convene building CRT to whatever extent possible.
- ☐ Prepare formal statement on disaster status.
- ☐ Schedule and announce time and location for emergency staff meeting.
- ☐ Identify most gravely affected students, staff, and families.
- ☐ Determine need for outside resource people and notify as appropriate.
- ☐ Assign trained staff or community professionals to:
  - ☐ Provide grief support;
  - ☐ Develop and distribute discussion questions to teachers;
  - ☐ Stand in for absent/affected substitute teachers;
  - ☐ Monitor school grounds and contact families of missing students or students leaving without permission; and
  - ☐ Distribute lists of community resources and follow-up information.
- ☐ Follow procedures applicable to student death if needed.

Bereavement and Grief

Personal Loss

To be human and alive means we will experience losses in our lives; There are different types of losses, and some are more significant than others; These losses may include:

- Loss of money and personal possessions by theft or misfortune
- Loss of friends through moving, a change of schools or teachers
- Loss of health
- Breakup of a close relationship
- Separation
- Divorce
- Death of a family member, friend, school mate, teacher, pet, idol, or celebrity

Reconciling oneself to a minor loss may require only a few moments or hours; Recovery from a major loss may require weeks, months, or even years. Experiencing a major loss through death or participating in intervention and assisting others in the grieving process confronts everyone involved with the reality of their own mortality; It is as Leo Buscaglia writes in ***The fall of Freddie the leaf: A story of life for all ages*** ". . . no matter how big or small, how weak or strong; We first do our job; We experience the sun and the moon, the wind and the rain; We learn to dance and to laugh; Then we die."

Whether a minor or major loss has occurred, most persons experience bereavement and grief; and for many people a crisis state is precipitated; It is important that the crisis counselor keep in mind it is not whether other people believe the loss is major or minor that determines the impact of a loss.

Bereavement and Grief

Personal Loss

To be human and alive means we will experience losses in our lives; There are different types of losses, and some are more significant than others; These losses may include:

- Loss of money and personal possessions by theft or misfortune
- Loss of friends through moving, a change of schools or teachers
- Loss of health
- Breakup of a close relationship
- Separation
- Divorce
- Death of a family member, friend, school mate, teacher, pet, idol, or celebrity

Reconciling oneself to a minor loss may require only a few moments or hours; Recovery from a major loss may require weeks, months, or even years. Experiencing a major loss through death or participating in intervention and assisting others in the grieving process confronts everyone involved with the reality of their own mortality; It is as Leo Buscaglia writes in ***The fall of Freddie the leaf: A story of life for all ages*** ". . . no matter how big or small, how weak or strong; We first do our job; We experience the sun and the moon, the wind and the rain; We learn to dance and to laugh; Then we die."

Whether a minor or major loss has occurred, most persons experience bereavement and grief; and for many people a crisis state is precipitated; It is important that the crisis counselor keep in mind it is not whether other people believe the loss is major or minor that determines the impact of a loss.

It is instead the personal subjective response of the individual to the loss.

People who suffer major losses often find it difficult to journey through the grief process and will choose to ignore it or deny it in an effort to protect themselves from the emotional pain; People who do not allow themselves to go through the grief process will often become either depressed, perhaps engaging in the self-destructive behaviors that can follow, or become angry and bitter and exhibit the abusive behaviors that can accompany an angry response;

When someone faces the necessary adjustments to major losses, concentration is difficult, learning decreases, and frustration, stress, and conflict increase; Therefore, it is important for counselors to be aware of losses, to evaluate each grieving person, and then provide the appropriate support for each individual.

Symptomatic Behaviors Common to Bereavement & Grief

There are common behavioral responses to the death of a loved one or to any other major loss such as divorce, rape, etc. These behaviors are often referred to as the stages of grief or the colors of grief. Grief behaviors or responses to loss do not necessarily follow any particular order of progression.

These responses can occur in any order, can reoccur in any order, and can remain for differing lengths of time. They are described in the paragraphs that follow.

- **Shock** is one response. It is a kind of numbness with accompanying behaviors such as confusion, forgetfulness, lack of feeling, not eating, not sleeping, poor concentration, and inconsistent behavior.

- **Panic** is a common response that includes rapid heart beat and pulse, shaking, nausea, light headaches, dizziness, confusion, and other physiological reactions.

- **Denial** is one of the most common feelings of loss. Individuals are especially inclined to deny the existence of the loss by refusing to think or talk about it. They will often say, *"I'm okay. I just don't think about it."* They refuse to believe the loss is real.

- **Depression** is a common response with the extreme consequences of high risk behaviors such as substance abuse, sexual promiscuity, and suicide among teenagers and young adults. Less extreme consequences are lack of focus, exhaustion, over-sleeping, poor achievement, loss of self-esteem, punishment, confusion, self-blame, anger, resentment, conflict, loss of support relationships, and further depression.

- **Anger** is another common response. The extreme consequences of which can be equally as serious. Anger can result in a lack of focus, poor achievement, disobedience, verbal abuse, vandalism, physical abuse, punishment, blaming others, resentment, loss of support relationships, loss of self esteem, bitterness, and the beginning of a cycle of abuse.

- **Bargaining** is another response. Individuals will try to be perfect, act according to a self-prescribed formula, and try to act in a way that might return life back to normal as they knew it. They may comment, "*Let's go back to the way it was.*"

- **Guilt** is another common feeling and results in behaviors of self-blame and loss of self-esteem. *"If only I . . ."* comments are common.

- **Acceptance** is a welcomed feeling in the grief process. It is during this stage that counselees will say, *"This is the way it is. I have to go on."*

- **Hope** is another welcomed response to loss. Counselees begin to feel they have a bright future. They no longer blame themselves or others, and they are able to again

love themselves and others and begin to exhibit trusting behaviors.

Counseling Persons Experiencing Loss or Grief

When a major loss occurs in a person's life, he or she is plunged into one of the less-welcome states mentioned previously. As a result, a disruption is experienced in his or her ability to concentrate, achieve, learn, and in his or her relationships. In order to return individuals successfully to their developmental tasks of social, intellectual, and physical skills, counselors often need to assist them in progressing through the grieving process.

Major losses that are not appropriately addressed will eventually set the counselee back. Delaying the grieving process is not beneficial. Often students at the middle school level or older are just beginning to recognize major losses from early childhood. Sometimes, earlier losses were not taken seriously by parents, who thought the child was too young to notice or to deal with the loss.

Parents may feel their child is coping or has successfully coped because little emotional behavior is displayed. Parents, often struggling with the same loss, may not recognize the child's need to process grief.

For these children, the loss is experienced for the first time as a teenager or, worse yet, as an adult. These children also experience grief and the accompanying lack of concentration or disruption to school, work, and relationships at the time they face their loss.

Ideally, major losses would be dealt with and needs met through the family, extended family, network of friends and neighbors, and church or other family support institutions; but this is often not the case. In order to provide the support young people need to complete this crucial transition and to get on

with their lives, counselors must be prepared to provide the following:

- ✓ Immediate one-on-one crisis counseling
- ✓ Crisis counseling for parents is occasionally needed
- ✓ Assessment of the family support system
- ✓ Referral to a grief support group
- ✓ Referral to outside family agencies

Group counseling can be very beneficial to children and adults. Individuals who are in a support setting have the opportunity to learn from each other, to recognize that others are experiencing or have experienced the same feelings, to cry in a safe environment, to remember without fear, to share with confidentiality and respect for each other, to learn about the grieving process, to be a support and resource to each other, and to learn how to appropriately communicate needs and have them met.

The counselor's role is to facilitate the grieving process through validation and helping the counselee to develop coping skills. Information on how to set up a grief counseling support group and session plans in **Bereavement and Grief: Other Resources** beginning on page 133.

WHAT TO EXPECT IN NORMAL GRIEF

You can expect that . . .

Your grief will	take longer than most people think.
	take more energy than you would have ever imagined.
	involve many changes and be continually developing.
	show itself in all spheres of your life – psychological, social, and physical.
	depend on how you perceive the loss.
	entail mourning not only for the person, but for the hopes and dreams you held for and with that person and for the needs that will go unmet because of the death.
	involve a wide variety of feelings and reactions such as depression and sadness.
You will	grieve for many things, both symbolic and tangible – not just the death alone.
	grieve for what you have lost now and for what you have lost for the future.

The loss will resurrect old issues, feelings, and unresolved conflicts from the past.

You may	feel some anger and depression such as irritability, frustration, annoyance, and intolerance, even at those trying to help.
	feel anger and guilt, or at least some manifestation of these emotions.
	have some identity confusion as a result of the major loss and the fact you are experiencing reactions that may be quite different for you.
You may	have a lack of self-esteem.
	have a lack of self-concern.
	experience grief spasm – acute upsurges of grief that occur suddenly with no warning.
	have trouble thinking – memory, organization, intellectual processing, and decision making.
	feel like you are going crazy.
	be obsessed with death and preoccupied with the deceased.
	find yourself acting socially in way that are different from before.
	begin a search for meaning and may question your religion and philosophy of life.

Acknowledgments

Jane Salmon, PHN, JS, Bereavement Coordinator, Hospital Home Healthcare Agency of California

Grieving by Theresa Rando

Bereavement and Grief

Other Resources

WHAT COUNSELORS NEED TO KNOW FOR CHILDREN COPING WITH GRIEF

1. Tell the truth.
2. Think like a child.
3. Avoid judgment.
4. Use appropriate language.
5. Acknowledge, explore, and accept feelings.
6. Provide a safe, open atmosphere.
7. Be a role model.
8. Provide an opportunity for sharing beliefs.
9. Acknowledge the importance of death.
10. Involve students in activities that provide opportunities to remember because memories are comforting, signify the importance of the deceased person, represent the importance of life and death, and recognize the reality of one's personal pain/loss/grief. Memories fill an empty space.

INTERVENTION STRATEGIES AND ACTIVITIES

Group Counseling

In setting up a group counseling situation, the following points may be helpful.

1. Group members should establish group rules and discuss them.
2. Discuss the Colors, or Stages, of Grief.
3. Create Memory Notebooks.
4. Read ***Everett's Story: Learning to Say Good-Bye*** or other small books about loss.
5. Have the members discuss the story or write letters to Everett to share their experience with loss.
6. Write your own story of loss and share it with others in the group.
7. Write letters to each other on behalf of the deceased.
8. Write letters to the deceased.
9. Discuss myths about grief.
10. Draw a picture of a happy time with the deceased and share it with the group.
11. Discuss how to assist others with grief.
12. Identify each one's resources for getting help and needs to be met.
13. Create a memorial collage including the deceased's picture mini-garden.
14. Have members share their dreams of the deceased and discuss them.
15. Discuss the words used to describe and define death.
16. Share pictures of the members' deceased loved ones.
17. Share about funerals and discuss their purpose.
18. Write letters to a close family member who is dying.
19. Remember a funny time with the deceased and share it.

Grief and the Adolescent

Unfortunately, the needs of the bereaved teenager have been sorely overlooked for decades. In many grief recovery programs, support is often available for younger children and adults, but there is a definite void in teen services.

Adolescence is perhaps one of the most difficult and confusing stages in life. It is a time of change, and with every change comes a grieving process. For example:

- The teenager who has a brother or sister move out of the house to get married or go to school will have to adjust to life in the home without their sibling. Meals and family events will not be spent together as frequently as in the past.
- Divorce in a family will also bring about a grieving process as one parent leaves the home.
- Children who have been abused or sexually molested will experience the loss of innocence and control of their bodies, which is a very painful grieving process.
- The dating process, a very natural process in adolescence, also involves grief as relationships build and then dissolve as the partners discover who they are and what they want in life.
- Death of a pet. Losing a pet can bring about profound grief in many children and adults alike. A pet is one of the few sources of unconditional love that life affords us. We can tell a pet our secrets, and in most cases, the pet is always glad to see us.

These are only a few of the grief issues that a teen may experience as a natural part of growing up. Add to these experiences the death of a loved-one, and you are likely to find a child who is terribly confused and in great pain.

Making a collage can be a creative way of enhancing healing during the grief process. Let the teenager gather magazines and cut out words and pictures that remind them of the deceased and place them on construction paper. When they complete this project, they will find that they have told a story through their collage.

These collages often become treasured items. Frequently they are placed in a visible place in the home where people visiting will ask questions about it, affording the teen the opportunity to talk about their loved one without having to bring up the subject themselves.

Help the teenager identify what they need during this time, and encourage them to let others know what they need. The common complaint of many bereaved persons is that people don't seem to care and are not around when you need them. Frequently people are not around because they don't know what to do or say, and they back off for fear of creating more pain. If we don't tell people what we need, we can remain a victim and victims seldom heal.

Remember, even though the teenager is striving for independence, he or she still needs you! Your presence and the expression of genuine support will be a gift they can carry with them for a lifetime (Linda Cunningham/1992).

Grief Support Group Sessions

The following group session plans were developed with middle school age students in mind, but they can easily be modified for younger or older audiences. Middle school students, like many others in group counseling, often respond better to an activity approach. The best discussions often develop as group members are participating in an activity or in sharing the results of their project or activity. Activities require members to participate in some way – either privately as they think, reflect, and then plan their project or openly as they share their projects with a partner, cooperative group, or the larger counseling group. Through the activity, the member focuses for a period of time, either directly or indirectly, on their loss and often begins to remember their relationship with their loved one, identify the losses, and recognize the blessings.

This approach is comfortable for all age groups, but especially for school-age individuals. Students, like most adults, don't want to walk into a group of strangers and begin talking about painful experiences and pouring their hearts out.

They feel safer working on a project or activity and then, through the activity, sharing an intimate moment with the group, or maybe with just one other person in the group. The important thing is that they remember and begin to enjoy and/or deal with the memories, express their feelings, learn about the grief process, recognize that it is a normal part of loss, and identify resources for personal support,

Session I

Materials

1. One manila folder per person
2. Colored markers or crayons
3. One Colors of Grief handout for each person (on the next page)

Objectives

1. To get acquainted
2. To discuss the group purpose

Group Work

1. Have members pair up and quickly interview each other, and then take turns introducing each other to the group by telling the person's name and two facts about their partner.
2. Discuss the purpose of the group:
3. A. Why each was invited to the group
   B. Why it is normal to grieve after a loss
   C. Why it is important to grieve
4. Brainstorm and discuss the rules this group should follow. Ask the members of the group to agree to respect each other by observing the rules. Keep the rules simple, and be sure to include that anything the members of the group say is to be kept confidential.
5. Hand out and discuss the **Colors of Grief**. Ask members to volunteer to read aloud the different stages, or feelings, of loss. Ask participants to put their thumbs up if they have had those feelings. Affirm that these feelings are normal; they are part of the grief process; they will not be experienced in any particular order; and this grief process will eventually result in acceptance and hope – if they will allow themselves to grieve.
6. If time allows, hand out folders, which will be used as Memory Notebooks, to each person to title and decorate. Members will then keep the class activities and handouts in the notebook.

Closure

1. As the members are working on the folders, walk around and ask each one to tell you which stage of grief she or he is presently experiencing.
2. Collect the folders.

COLORS OF GRIEF

Grief is the feeling people have when someone they love dies. Every person and every situation is unique. Therefore, no one feels exactly the same grief feelings as someone else. Most people feel some of these feelings for a long time or a short time. We all need support from our friends and our faith in times of grief.

SHOCK
A kind of numbness,
not hungry, forgetful,
bothered by insignificant
things.
Can't think, can't feel.
(I'm in a daze.)

DENIAL
This can't be true.
I just dreamed it.
It didn't happen.
I'll probably see him or her
(the dead person)
tomorrow. I don't want
to talk about it.
(I'm afraid to believe it.)

ANGER
This isn't fair.
Why did it have to happen?
It's somebody else's fault.
This is messing up
my life.
(I'm hurt and afraid.)

BARGAINING
Maybe I can get them back.
I'll do something to
make it all better.
If I try hard enough, maybe
this won't be true. We'll
go back to the way it was.
(I think I can change
the facts.)

GUILT
If only I could have done something.
Maybe it was my fault. I should have been
nicer to the person. Why don't I feel sad
that he or she died?
(I'm afraid I'm bad and unloved.)

DEPRESSION
I can't change it.
It's too much for me.
Nobody cares about me.
I'll never be happy again.
Life is too hard.
Why try?
(I feel powerless, alone,
and unloved.)

ACCEPTANCE
I don't like
what happened.
This is the way life is.
I can live with this.
I can handle it. I can go on
with my life.
(I feel relieved.)

HOPE
I can trust others
to help me. I can
look forward to
happy times again.
(I know I am loved
and lovable.)

Session II

Materials

1. The storybook titled, ***Everett Anderson's Good-Bye***
2. Writing paper and pencils

Objectives

1. To define and discuss death
2. To remember the loved one who died
3. To identify and express feelings of loss
4. To begin to deal with unfinished business

Group Work

1. Have participants brainstorm all of the words used to describe death or used instead of the word death. List these on the board or overhead. Ask why they think so many other words are used instead of the word death?
2. Read the book, ***Everett Anderson's Good-Bye,*** showing the pictures and allowing the members time to process the story.
3. Ask each member of the group to write Everett a letter about his dad's dying.
4. Move from person to person and assist them by asking questions when needed.
5. Ask the group to finish the letters, and then ask if you can read them. Finally, ask if you can read them to the group.
6. Read those letters you were given permission to read, and encourage any discussion that may follow each letter.

Closure

1. Ask the group to identify which part of ***Everett Anderson's Good-Bye*** they think is like their own story of loss.
2. Include the letters in the members' folders and collect the folders.

Session III

Materials

1. One **My Story** handout per person (on the next page)
2. Writing paper and pencils

Objectives

1. To remember the loved one who died
2. To identify and express feelings of loss
3. To begin to deal with unfinished business

Group Work

1. Have the group break into small groups of four persons each.
2. Hand out **My Story** worksheets to each person and have each one tell their own story on the worksheet.
3. Move from person to person to assist if needed.
4. As the group finishes, ask for one person in each group to volunteer to share their story with their small group.
5. Once that person shares his or her story, ask the small group members to write a note or letter to that group member on behalf of his or her loved one who died. Ask the members to write what they think the deceased would want to say now if they could. Also ask the person who shares to write a letter to his or her loved one and tell them the things that she or he would like for them to know if they could.
6. The group members should then give their letters to the sharing member to read and place into their Memory Notebook.

Closure

1. Ask this question. *"If you had the chance to say something to your loved one who died, would you? Think for a minute to yourself. What would it be?"*
2. Collect the folders.

MY STORY ABOUT WHAT HAPPENED

Session IV

Materials

1. Writing paper and pencils
2. Drawing paper
3. Markers or crayons
4. **Myths About Grief** worksheets (on the next page)

Objectives

1. To remember the loved one who died
2. To identify and express feelings of loss
3. To recognize myths about grief

Group Work

1. Have members break into small groups to continue sharing and note writing activity from Session III. Move from person to person to assist if necessary.
2. Have the group members give their letters to the sharing member to read (either aloud or silently) and place in their Memory Notebook.
3. Discuss the **Myths About Grief** within the larger group.
4. Have the group draw a picture of a happy time with the person who has died.
5. Have them share the pictures and tell about the happy time.
6. Ask each person in the group individually if you can display their drawings in your office.
7. Have the group place all their work into their Memory Notebooks.

Closure

1. Ask the group to think about that happy time again.
2. Then ask them, *"Why do you think these kinds of memories are important for us to remember?"*

SOME MYTHS ABOUT GRIEF

TEARS are a sign of WEAKNESS.
CHILDREN should be SHELTERED from grief.
It's best to AVOID DISCUSSING A LOSS with a grieving person.
An end to grief means an END TO CARING about a loved one.

WRONG. Tears are a natural way to release intense feelings. There is no shame in showing how you feel about losing a loved one.

NOT TRUE. Kids need to grieve. Tell them about the loss in an honest, loving way. They, too, need to talk about their grief.

FALSE. Grieving people are grateful for friends who share memories and talk about the pain created by the loss.

NOT AT ALL. Love lasts beyond grief through a commitment to living life fully.

BEST COPY AVAILABLE

Session V

Materials

1. Writing paper and pencils
2. **You Can Help a Grieving Person** worksheet (on the next page)

Objectives

1. To remember the loved one who died
2. To identify and express feelings of loss
3. To identify how one can help a grieving person

Group Work

1. Have the members break into small groups to continue sharing and the note writing activity from Sessions III and IV.
2. Have group members give letters to the sharing members to read and to place into their Memory Notebooks.
3. Discuss the worksheet, **You Can Help a Grieving Person**, within the larger group.
   a. Ask the group to interpret from their own experiences how each helping action could be of help to someone.
   b. Ask them to apply each helping action for themselves. "*How would you lend a helping hand.*"
4. Brainstorm and list on the board or a chart the names of the people to whom they personally could go for help or support when they are feeling down.
5. Have each person in the group write down the names of three people in their personal lives whom they could ask for help or to whom they could tell their feelings or problems.
6. Have the group place the lists in their Memory Notebooks.

Closure

1. Say, "*Raise your hand if there is someone in this group you could ask for help or talk to about your feelings.*"
2. Then ask, "*How long do you think a grieving person might grieve and need some help?*"
3. Then suggest they raise their hands if they can agree to be there for each other for a while, knowing that it might take a year or more to grieve for some.

YOU CAN HELP A GRIEVING PERSON

OFFER EMOTIONAL SUPPORT

BE PRESENT IF YOU CAN

Just being near can be a tremendous help. Don't be afraid to give the person a hug or hold his or her hand. (If you can't be present – write, phone, send flowers, etc., to show your concern.)

BE A GOOD LISTENER

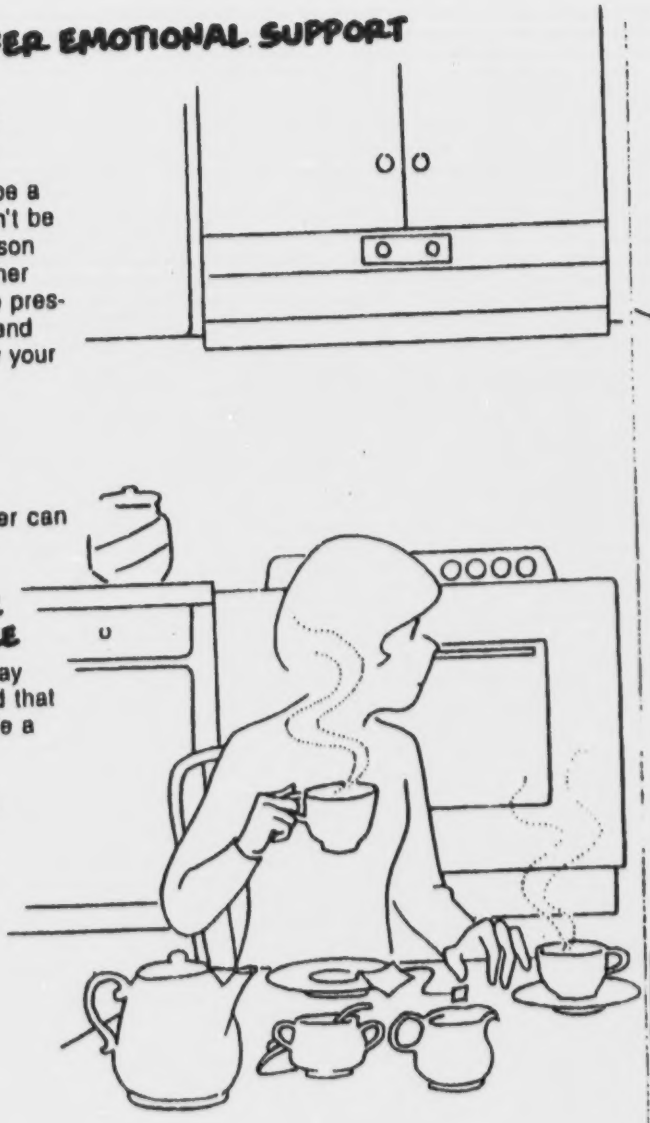
A sympathetic listener can be a great comfort.

ENCOURAGE INDEPENDENCE

A grieving person may need to be reminded that he or she can handle a new way of life.

BE PATIENT

It takes time to accept loss and to deal with changes.



PROVIDE PRACTICAL ASSISTANCE

HELP WITH CHORES

Relieve the person of some chores such as grocery shopping, doing housework, etc.

ASSIST WITH CARDS AND LETTERS

Offer to help write thank-you notes and other correspondence.

LEND A HAND WITH MEALS

Bring something to the person's home, or extend an invitation for dinner at your home.

ANSWER THE TELEPHONE

Offer to screen phone calls and take messages.

Remember -- recovery takes time. Continue your support for as long as it's needed.

SCRIPTOGRAPHIC

157

BEST COPY AVAILABLE

Session VI

Materials

1. Writing paper and pencils
2. Poster paper
3. Markers or crayons or colored pencils
4. Scissors and glue
5. Magazines

Objectives

1. To remember the loved one who died
2. To identify and express feelings of loss
3. To create a memorial

Group Work

1. Have members break into small cooperative groups of four each to continue sharing and the note writing activities from sessions III, IV, and V.
2. Have the group members give their letters to the last member to share his or her story to read and place in their Memory Notebooks.
3. Discuss what a memorial is.
4. Describe the project by telling the group it is a memorial collage they will make using magazine pictures, words, and photographs of the deceased.
5. Have the members of the group design the memorials.

Closure

Ask the following questions.

1. What is a memorial?
2. Why is a memorial important to us?
3. How is a memorial a symbol of respect?

Session VII

Materials

1. Poster paper
2. Markers, crayons, and colored pencils
3. Scissors and glue

Objectives

1. To remember the loved one who died
2. To identify and express feelings of loss
3. To complete their memorials

Group Work

1. Have the group complete for their memorials their loved ones.
2. Have members of the group include their personal photographs.
3. Visit with each person during the process of creating the memorial and assist them by asking questions, inquiring about the design and photographs, etc.
4. As the group begins to finish the memorials, ask them to share their memorials by explaining the symbols, words, pictures, etc., that were chosen.

Closure

1. Tell the group the next session will be the last for a while, but they will be meeting occasionally in the future.
2. Then tell them that next week is a pizza party and they can finish sharing the memorials.

Session VIII

Materials

1. Pizza and drinks
2. Napkins and cups
3. Poem mounted on construction paper (one for each person)
4. Participant evaluation forms (on the next page)

Objectives

1. To relax and have fun with each other
2. To review group outcomes and debrief the group
3. To evaluate the group's outcomes

Group Work

1. Serve pizza and drinks.
2. Visit and eat.
3. Share any last memorials
4. Complete the Memory Notebooks by giving each member of the group a copy of the poem, you have chosen to include in their notebooks.
5. Ask for a volunteer to read the poem.
6. Discuss the meaning of the poem, and encourage members of the group to post it in their rooms.
7. Review with the group which activities they liked best.
8. Review with them what they learned or thought was helpful from the group sessions.
9. Give each person in the group an Evaluation Form to fill out.
10. Let the group take home their notebooks.

Closure

1. Remind the group they have each other, the counselor, and their support resources to depend on whenever they need them.
2. Remind them that you will be getting them together occasionally.
3. Have the members of the group take home their notebooks.
4. Say Good-Bye with hugs, handshakes, or pats on the back.

Grief Support Group Evaluation

1. What did you think was good or helpful about the group?

2. Did you think being in the group was helpful to you? Why?

3. Did you feel that others in the group were helpful to you? How?

4. Did you feel you were helpful to others in the group? How?

5. What would you say or do for a friend who just had a death in their family?

6. Would you recommend this group to others? ☐ Yes ☐ No.

7. Did you want to be in this group at the beginning? ☐ Yes ☐ No.

8. Are you now glad that you were in the group? ☐ Yes ☐ No.

Comments.

Annotated Bibliography

From
School Crisis Survival Guide
by
Suni Peterson and Ron L. Straub
The Center for Applied Research in Education
West Nyak, NY 10995, 1992

Primary Grade Level

Alexander, Sue. Nadia the Willful. New York: Pantheon Books, 1983.
Willful Nadia's favorite brother dies and her father decrees that no one can talk about him. This book emphasizes how important it is for one to talk about death and the life of the deceased.

Anders, Rebecca. A Look at Death. Minneapolis: Lerner Publications, 1978.
This book describes the sadness that comes with death and the importance of mourning. It is compassionate and positive.

Bartoli, J. Nonna. New York: Harvey House, 1975.
This book demonstrates the patience and understanding needed by young children through the death of a young boy's grandmother.

Bernstein, Joanne E. When People Die. New York: Dutton, 1977.
This book answers with assurance the many questions children have after a death.

Brown, Margaret. The Dead Bird. Reading, MA: Addison-Wesley, 1965.
This classic book describes the reactions of a group of young children as they find a dead bird.

Carrick, Carol, The Accident. New York: Seabury Press, 1976.
Christopher witnesses the accidental death of his dog. He goes through the grief process rehearsing trying to find ways to undo the accident until he reaches acceptance of the death.

DePaola, Tomie. Nana Upstairs and Nana Downstairs. Middlesex, England: Penguin Books, 1973.
This book deals on a very simple level with the concepts of death through the death of a great-grandmother and the impending death of a grandmother.

Fassler, Joan. My Grandpa Died Today. New York: Human Science Press, 1971.
This is an illustrated book about a young child's reactions to the death of his grandfather.

Herriott, James. The Christmas Day Kitten. New York: St. Martin's Press, 1986.
This book beautifully describes a relationship between a dying cat and its owner. A time span of a year shows the healing that comes with time.

Kantrowitz, Mildred. When Violet Died. New York: Parents Magazine, 1973.
This book shows through the death of a bird how very important a ceremony is in accepting death.

Sanford, Doris. It Must Hurt a Lot: A Child's Book About Death. Portland: Multnomah Press, 1985.
When a little boy's dog is killed by a car, he experiences grief and loneliness. This book discusses his feelings and the outcomes. It includes instructions for adults using this book with children.

Viorst, Judith. The Tenth Good Thing About Barney. New York: Atheneum, 1971.
Through remembering all the good things about his deceased cat, this boy learns to accept death as a reality of life.

Wright, Betty. My New Mom and Me. Milwaukee: Raintree Children's Books, 1981.
This book sensitively explores through conversations with a cat the reactions to a death of a mother and the arrival of a new mother two years later.

Zolotow, Charlotte. My Grandson Lew. New York: Harper, 1974.
This book shows how a young boy lessens his loneliness over the death of his grandfather through sharing the memories.

Upper Elementary Grade Level

Anderson, Leone Castell. It's OK to Cry. Elgin, IL: The Child's World, 1979.
The death of an uncle creates discussion between two boys about their feelings, funerals, and what happens after death.

Bunting, Eve. The Happy Funeral. New York: Harper and Row, 1982.
Through the preparation of her grandfather's funeral, a young Chinese girl learns to come to terms with her own grief and the comfort of her cultural rituals.

Byars, B. Good-Bye Chicken Little. New York: Harper and Row, 1980.
This book depicts an offbeat family providing emotional support for a young boy who is very fearful after the death of both his father and his uncle.

Clardy, Andrea Flech. Dusty Was My Friend: Coming to Terms With Loss. New York: Human Sciences Press, 1984.
This book explores coming to terms with feelings after a friend is killed in a car accident.

Cleaver, Vera and Bill. Grover. Philadelphia: J.B. Lippincott, 1970.
When a dying mother kills herself, a father and his eleven-year old son struggle with their grief and their relationship.

Donnelly, Elfie. So Long, Grandpa. New York: Crown, 1981.
A young boy copes with his grandfather's expected death due to cancer and his recovery afterwards.

Green, Constance C. Beat the Turtle Drum. New York: Viking Press, 1976.
This book describes the relationship between two sisters before the death of one. The remaining sister experiences the many reactions common to children: anger, feeling the favored sister has died, and confusion over her parents' reactions to the death. The book details feelings about death and its reactions.

Hegwood, Mamie. My Friend Fish. New York: Holt, 1975.
This is the story of a black urban child and his friendship with a fish who dies.

Lee, Virginia. The Magic Moth. New York: Seabury Press, 1972.
This book shows the different reactions of the four surviving children in a family that has lost its middle child.

MacLachlan, Patricia. Sarah, Plain and Tall. New York: Harper and Row, 1982.
This book describes the father's search for a new wife after this little girl's mother has died. This Newberry Award Winner shows the acceptance and growing love for the new mother.

McLendon, Gloria H. My Brother Joey Died. New York: Julian Messner, 1982.
This book covers the gamut of problems resulting from the death of an older brother: guilt, problems in school, the funeral, and harsh comments from others. This is a good discussion book.

Miles, Miska. Annie and the Old One. Boston: Little, Brown, and Co., 1985.
A story depicting the natural way of life and death to a young Indian girl whose grandmother believes she will die when the rug she is weaving is completed.

Paterson, Katherine. Bridge to Terabithia. New York: Thomas Y. Crowell, 1977.
The imaginary world of two friends ends abruptly in the death of one of the friends. This book, winner of the Newberry Award, sensitively describes the guilt felt by the survivor.

Rofes, Eric E. The Kids' Book About Death and Dying. Boston: Little, Brown and Co., 1985.
This book is a discussion of a students' group exploring the different kinds of death, different emotional reactions, and different approaches to life after death.

Smith, Doris Buchanan. A Taste of Blackberries. Elgin, IL: Chariot Books, 1981.
After a friend dies of a bee sting, this little boy feels guilty and experiences a full range of emotional reactions to the death of the friend.

Stolz, Mary. The Edge of Next Year. New York: Harper and Row, 1974.
When a boy's mother dies in an auto accident, he is left with a little brother and an alcoholic father. The book demonstrates how different people deal with loss in different ways and provides healing even in the face of hopelessness.

Tolan, S.S. Grandpa and Me. New York: Scribner's, 1978.
An *eleven-year old girl speaks candidly about her coping with the increasing senility of her grandfather and his eventual suicide.*

Wallace, Bill. A Dog Called Kitty. New York: Pocket Books, 1980.
This book demonstrates many losses through the relationship with a dog and its death. This is a good book for generating discussion.

White, E.B. Charlotte's Web. New York: Harper and Row, 1952.
A classic story using animals to portray the natural events of life and death.

Zim, Herbert and Bleeker, Sonia. Life and Death, New York: William Morrow and Co., 1980.
This book provides factual answers to questions about life and death. It deals sensitively with physical facts, attitudes, traditions, and feelings.

Teens

Aaron, C. Catch Calico. New York: Dutton, 1979.
This story is about a fourteen-year old and his grandfather's search for a wildcat. The search ends with the boy having to shoot the cat and deal with his grandfather's death from the cat's rabid bite.

Agee, J. A Death in the Family. New York: Bantam, 1969.
This Pulitzer Prize winning novel offers incredible insights into the impact of a death on the family and the misunderstandings that occur.

Angell, J. Ronnie and Rosie. Scarsdale, NY: Bradbury Press, 1977.
A young suburban adolescent must learn to cope with her family's move and her father's sudden, accidental death.

Arundel, H. The Blanket Word. Nashville: Nelson, 1973.
This book portrays the idealism and self-doubts of a young college student as she finds new meaning in relationships after the death of her mother.

Buck, Pearl S. The Big Wave. New York: Lothrop, 1948.
This novel features a young Japanese fisherman, left to deal with the destruction of his entire village, as he changes his views of life and death.

Donovan, John. I'll Get There. It Better Be Worth the Trip. New York: Harper and Row, 1969.
This book provides a tough, realistic and sensitive look at a young teen who suffers several losses: death of a custodial grandmother, a move to New York City to live with an alcoholic mother in the midst of a divorce, and his dog's death. There is much to learn from his growing up.

Guest, Judith. Ordinary People. New York: Ballantine Books, 1980.
This is the powerful story of a family bereft by unexpressed grief over the death of one son and the attempted suicide of the other son.

Huntsberry, W.E. The Big Hangup. New York: Lothrop, 1970.
This book follows the guilt and grief of young survivors after a friend has been killed in an auto accident involving teenage drinking and driving.

Krementz, Jill. How It Feels When A Parent Dies, New York: Alfred Knopf, 1981.
Eighteen children discuss what happened to them when their parent died. Children aged seven to sixteen tell of their feelings about the death and remarriage of the remaining parent. This is a useful resource for teachers and counselors as well.

LeShan, Eda. Learning to Say Good-Bye – When a Parent Dies. New York: Alfred Knopf, 1981.
This book about recovery from a parent's death is helpful to both young people and the adults who are helping them.

Rabin, G. Changes. New York: Harper, 1973.
A teenage boy must learn to find the courage and strength to deal with the death of his father and the changes it brings to his life: a move, change in lifestyle, and the normal pressures of adolescence.

Richter, Elizabeth. Losing Someone You Love: When A Brother or Sister Dies. New York: G.P. Putnam and Sons, 1986.
Sixteen young people describe their emotions and how they learned to cope with a sibling's death.

Grollman, Earl A. Explaining Death to Children. Boston: Little, Brown and Co., 1980.
This book delivers practical information for parents to help their child understand death through theology, psychology, biology, and culture.

Dunne, Edward, McIntosh, John, and Dunne-Maxim, Karen. Suicide and its Aftermath: Understanding and Counseling the Survivors. New York: W.W. Norton and Co., 1987.
This book offers a comprehensive collection of essays addressing many perspectives of the survivors of suicide, with special chapters devoted to sibling survival and adolescent suicides.

Hughes, P.R. Dying is Different. Mahomete, IL: Mech Mentor Education, 1978.
This book promotes discussion about the differences between life and death and the feelings and rituals necessary for recovery.

Marsoli, Lisa Ann. Things to Know About Death and Dying. Morristown, NJ: Silver Burdette Co.
Information is given about twenty-five different aspects of death: pets, wills, suicide, hospice, physical death and funerals, to name a few.

Rudolph, Margarita. Should the Children Know? New York: Schocken Books, 1978.
This book speaks sensitively of children's concerns and fantasies, suggesting honest sharing and ways to help young children.

Stein, Sara D. About Dying: An Open Family Book for Children and Parents Together. New York: Walker and Co., 1984.
A text is included for parents to read before reading the book with children. This book provides guidelines to assist parents and children when discussing feelings and actions related to any death.

Wolf, Anna. Helping Young Children to Understand Death. New York: Child Study Press, 1978.
This book presents typical questions frequently asked by children with constructive suggestions for family and school discussions.

Guidelines for Responding to a Student's Death

Adapted with permission from the Los Angeles Unified School District.

1. React to the student's death. Share your reactions with the class.
2. Let the students talk and write about their feelings.
3. Listen to what the students have to say. It is important not to shut off discussion.
4. If the student died of an illness and it is appropriate to do so, discuss the illness. This is especially useful for younger children who may need to separate the illness of the child who died from any medical problems his or her classmates experience.
5. Never tell young children, "God took Sally away because He loves her," because children will wonder if it is a good idea to be loved by God. Do not say, "Sally went to sleep." You may create a class of children afraid to go to sleep.
6. A regular day may be too hard for grieving students. Offer choices of activities, such as letters, journals, and discussions.
7. If the students want to, let them write sympathy notes to the parents or to a student who has suffered a loss. Provide an address or offer to deliver them.
8. If acceptable to the affected family, make sure that the funeral time is well publicized. They or you may also wish to include ideas on funeral etiquette.
9. If applicable to the affected family, share any cultural information related to the meaning of death and death observances that will help students understand and respond comfortably to affected family members.
10. Talk with students about their concerns regarding *what to say* to other bereaved students and the family of the deceased. Emphasize that trying to avoid grieving individuals or being overly solicitous to them will not help. Students should be themselves and share their caring feelings and support. Point out the need to resume normal relationships.
11. Remember, your class may remain quiet and depressed for some time after the death (perhaps even a month), and some students may begin to act out noisily and physically as a method of dealing with their feelings.

FORM C

Open-ended Questions for Classroom Discussion

Reprinted with permission from SWRL

1. What was it like for you when you heard the news?

2. Did/will you discuss it at home? How did it go?/How will it go?

3. If you were a member of _____'s family, what do you think you would want at a time like this?

4. How can you students help each other through this?

5. What other losses have you experienced?

6. What do we know about how (cultural group) respond to this type of loss? How can we respond in ways that are culturally respectful?

HOMICIDE
and
VIOLENCE

Homicide and Violence

Introduction

Focus: Why is this important? What is the scope of the problem?

- We celebrate violence in many ways. From cartoons to superhero movies, we see it as successful, funny, and entertaining.
- Many communities have accepted violence as an everyday occurrence and are tolerating it. Children live with it.
- Returning violence for violence does not protect people. It destroys families and continues the cycle of violence.
- The most affected and traumatized groups as a result of crime and violence are the youth, pre-schoolers, pre-teens, teens, and young adults.
- Emphasize **prevention/intervention**. Address the escalation of outbursts in families and violence in the community, and at school.
- Shift the energy from emergency responses to working on preventing the violence. Place the emphasis on community-based and school-wide programs that address the problem areas.

Goals:

- To assist children, teens, parents and other adults cope with their trauma from the experience
- Assist persons to identify themselves and others who need help
- Assist children and adults to resume regular activity, so they can maintain, as much as possible, the daily routine
- Assist with intervention and coping activities to help put the crisis event in perspective

Who is involved in the traumatic incident?

- How close into the actual involvement?
- What was his or her proximity to the center of the incident?
- What is his or her connection to the victim?
- Is there a *perceived danger* to self?

- Large scale trauma? Many persons involved
- Small scale trauma? Family, friends, small group
- Consider: age, ethnic/cultural background; sex; physical setting; available support persons; need for medical help

Emergency Response Crisis Management Activities

The members of the crisis management team who respond must be sensitive to the situation and understand the needs of those involved in order to provide assistance and support. It is best to follow these procedures.

Prior to crisis counseling

- Identify the incident, and evaluate the episode.
- What has already been done? What needs to be done?
- Who is the leader? Who is in charge?
- What does the leader expect from you?
- With whom will you work?
- With whom do you meet, and where do you meet them?
- What information is already known.

Do not underestimate the power of the police and the media.

Crisis counseling . . . Using the impact room . . . Triage

- Individual or small group?
- Large group?
- Age level?
- Type of group?

Suggested format for discussion

- Introduction
- Open discussion
  - Questions to be asked
    - What happened?
    - What do we know?
    - How do we know?
    - Why did it happen?
- Focus of discussion
  - Separate fact from fiction and rumor

Closure

- Recapitulation: review the group discussion.
- Share the common themes of the statements made during the session.
- Reassurance: help the persons cope with their experience.

  A. Consultation working together with other team members
  B. Debriefing with person in charge
  C. Referral recommendations
  D. Debriefing of others; Disseminate accurate information

- Ask leaders, teachers, and parents about their reactions to the events and ask for their suggestions for improvement.
- Evaluate ! !

BEST COPY AVAILABLE

Coping activities to resolve both the short term trauma and the long term trauma

- The Lifeline: have each person in the group draw a lifeline and mark in their *mountains* and *valleys* to show whether it was a good or bad year.
- Write a letter or make a drawing to send to the victim.
- Establish a memory wall or a memorial spot on which to post comments, feelings, notes, and drawings from others.
- Create a four-part drawing or story as a remembering activity.
    a. What happened?
    b. Where were you when it happened?
    c. What was the worst part?
    d. How do you feel now?

    Have those involved complete the "My Story About" form concerning the incident. It is important that this writing or drawing is a remembering activity and should be continued over several days or weeks.

- Have the members of the group create a freehand drawing of something associated with the trauma.
- Use toys or hand puppets, and have the puppets tell a story
- The *empty chair*
- Provide relaxation exercises.

A. MY VIEWS ABOUT:

B. WHEN IT HAPPENED, I WAS AT:

C. TO ME, THE WORST PART WAS:

D. AND NOW I FEEL:

Anticipated Responses to Crisis

from
Crisis Management Task Force
Under auspices of
Mental Health Association of Greater San Antonio

Homicide: Killing of one human being by another

Responses to Anticipate:

Anger: May be manifested in blaming oneself or others and in aggressive behavior.

Crying: May be listed as a response in conjunction with other tragic events. It is of little significance by itself unless it becomes prolonged or inappropriate.

Depression: Includes the inability to concentrate, failing grades, loss of interest in activities formerly enjoyed, truancy, absenteeism, sleep disturbances, and hyperalertness.

Fear: Including fear for oneself and others. Young children fear that one may lose a parent or be rejected. Often, young children develop separation anxiety, or the fear of losing a parent, and the fear of being alone.

Blame: Results from circumstances in which an individual was present and felt he or she should have intervened or protected the victim or should have been present to aid the victim. This can happen when a victim is a date, companion, or family member.

Regret: Usually revealed in remarks such as, "Why didn't I do more?" "If only I had done . . ." or "I wish I had been nicer . . ."

Blame and regret are two separate responses. Both can exist or each can exist independently of the other.

A tragedy such as homicide rarely causes drug or alcohol abuse, but it is likely to increase such behavior if it already exists.

BEST COPY AVAILABLE

The degree of response usually depends upon the closeness of the person to the victim or his or her exposure to the event. A child who witnesses a tragedy will experience a more profound reaction than one who hears about it. Adolescents are affected to varying degrees by events that happen to family members, friends, and classmates.

Grief and Resolving Loss

Impact: This stage is measured in hours and is oriented to the present. It is the realization of a sudden and unexpected loss and characterized often by denial and disbelief.

Recoil and turmoil: This stage is measured in days and is oriented to the past. Expressions of anger and hostility usually are the dominant feelings. Rituals and memorials are important.

Adjustment: This stage is measured in weeks. There is *no* steady progression into the next stage. Redirecting psychological energy into creative causes can help.

Reconstruction: This stage is measured in months and oriented toward the future and *letting go* of the relationship.

The Support System

Goal: To assist family members and friends through the loss and grief process.

Rationale: The establishment of a support system permits members to break their sense of isolation by joining others working through the grief process.

- This is an autonomous group. Selection of members is related to the shared problem. Members can help themselves by helping others.
- All members are faced with difficulty in resolving their grief. Provide information about the stages of grief and the knowledge that other members in the support group also experience this loss. Peer support is a common part of healing.

- The stages of grief are *not* experienced in any special order, nor will all persons reach each stage at the same time.
- To provide time for individual problem solving and room for peer support, limit the size of the group.
- Establish group standards and the importance of:
  a. Nonjudgmental acceptance of others
  b. Confidentiality
  c. Consistent attendance
  d. Honesty
  e. Helping attitude
- The members should have input to determine the length and frequency of the sessions.

Prevention and Intervention

The purpose of prevention and intervention is to keep violence from happening. To do this, it is imperative to go beyond emergency responses to prevention. Seek the basic programs that address the problem areas, and make crime prevention a top priority.

Prevention: Seeking ways to keep violence from happening.

- Develop an anti-violence curriculum and conduct workshops. Learn **conflict management** skills. Incorporate into the curriculum ways to help young people recognize how fights start.
- Utilize team efforts to provide community and school services and hotlines. Make this a cooperative effort.
- Establish a massive family/school/community project with improved open communications and cooperative connections to operate as a safety net for at-risk youth.
- Teach children and youth how to apply other options. Conduct weekly talk forums, and focus on creating a shift in attitude to value human life.
- Set up regular discussions on the hazards of violence.

- Create support groups on loss:
  - Through death
  - By divorce
  - Of property
- Provide school and agency newsletters with information about these support groups.
- Find **mentors** to help the youth examine and seek other options instead of resorting to violence.
- Provide monthly teacher forums on concerns about actions on campus.

Intervention: Deflect individuals from potential violence

- Attitude changes must be instilled in children and youth to develop ways to respond to difficult situations.
- Sensitize the persons to undercurrents of potential conflict. They need to watch their surroundings, and be alert for strangers or outsiders.
- Explore the types of behavior needed to avoid violence. Help them learn to walk away and **not** confront the leaders of a fight.
- They should learn to report the possibility of an incident to a trusted adult, and then spread the word **not** to show up for fights.
- Help them learn how to avoid spreading rumors or sharing inflammatory reports.
- Help develop an attitude that creates a desire to evade participation in fights or being a spectator at them. Remind them they should not go to the location of an incident or fight. *The bullet does not know you are an innocent bystander.*
- Revise school procedures to permit concerned students to be excused early to go home. Have the parents pick up the child.

Guidelines for Counselor Role:
Homicide/Violence
Dealing with Grief and Loss

1. Keep in contact with the Principal. Follow the crisis plan. Verify the loss. How many school children and/or staff were involved or in close proximity to the tragedy?

2. Provide factual information to Principal and school staff.

3. Be available and visit classrooms, work with teacher to lead discussion. Share factual information, evaluate the impact on students. **Listen** to the student response.

IMMEDIATE attention

a. First priority – classroom/staff closest to the tragedy.
b. Other classroom groups who may have some connection with the person(s) involved in the tragedy.
c. Provide time for individual counseling.
d. OTHERS AT RISK – Contact other counselors at neighboring schools. This outreach will ALERT other counselors to the possibility of siblings or cousins in need of help.
e. Provide information to parents and staff, and seek suggestions. Refer questions and concerns to the Principal.

LONG RANGE PLAN

4. Establish a student grief support group. Meet once a week for several weeks.

5. Two and three weeks after the tragedy, alert the school staff to **At-Risk Students** still attempting to cope with the loss. Explore with parents the possibility of additional individual counseling. Be prepared with referrals to community agencies.

6. FOLLOW-UP MEETINGS with the Principal and faculty for four to six weeks after the tragedy.

"Where do we go from here?" Explore the possibility of establishing a **Prevention Program.**

7. OTHER SUGGESTIONS: _____
_____
_____
_____

INTRNAL p.5

Resources

Contact:

Marjory Marvel
American Association of Retired Persons (AARP)
Widowed Persons Service
601 E Street NW
Washington, DC 20049

1. Customs of Bereavement
   A Guide for Providing Cross-Cultural Assistance
2. Bibliography on Grief and Loss
3. "I Wonder Who Else Can Help?"
4. "If I Only Knew What to Say"

Materials published by:

Active Parenting Publishing
810 Franklin Count, Suite B
Marietta, GA 30067-8943

1. Windows "Helping and Healing Through Loss
   A video-based program relating to grief and loss.
2. Windows "When You Want to Help"
   Booklet
3. Windows "When You Have Lost"
   Booklet

Peterson, Suni and Straub, Ronald. School Crisis Survival Guide. The Center for Applied Research in Education, West Nyak, NY 10995.
Management Techniques and Materials for Counselors and Administrators

Crisis Management: Fourth Edition. Developed by Crisis Management Task Force, Mental Health Association in Greater San Antonio, United Way of San Antonio and Bexar County. Underwritten by Colonial Hills Hospital. (512) 341-5131.
A resource tool for use by agencies, school districts, religious groups, and civic organizations.

HOMICIDE CHECKLIST

Reprinted with permission from SWRL

- ☐ Communicate with police liaison for clarification and instructions.
- ☐ Notify district superintendent.
- ☐ Notify district media liaison or school board member.
- ☐ Quell rumors.
- ☐ Notify building counselors, psychologists, and/or social workers.

With police approval:

- ☐ Convene CRT and assign duties.
- ☐ Inform closest friends of the deceased and provide support.
- ☐ Prepare formal announcement or written statement.
- ☐ Identify students, staff, and parents likely to be most affected by news.
- ☐ Announce time and place of emergency staff meeting.
- ☐ Assess need for additional community resources.
- ☐ Assign trained staff or community professional to:
  - ☐ Provide grief support to students;
  - ☐ Review and distribute discussion questions to teachers;
  - ☐ Stand in for absent/affected/substitute teacher; and
  - ☐ Distribute lists of community resources.
- ☐ Make official announcement.
- ☐ Hold emergency staff meeting
- ☐ As needed, assign team members and other staff to monitor grounds; notify parents, support staff, and feeder schools; provide support to staff; collect student belongings and withdraw student's name from school rolls.
- ☐ Implement long-term follow-up procedures.

ADDITIONAL RESOURCES

GUIDELINES TO DEVELOP A COUNSELOR RESOURCE FILE

Counseling and support are critical factors to a student's success on your campus. Students are receptive when the counselor can provide quality information and assistance.

When students and/or their families face serious problems that **go beyond the scope of the counselor's regular assignment**, the counselor can offer assistance by providing information regarding the variety of support resources within the district itself or the appropriate community agencies.

Each counselor or guidance office should develop a system to access the community agencies.

Consider the following:

1. **Name of the Agency**. Phone number, Address, **Name of a contact person associated with the agency**. Sliding Fee scale? Do they accept DPSS clients? How long is the wait time? Does the agency have any specialty services?

2. Place the information about each agency on a 3x5 index card, **or** Keep a community resource list by special service.

3. **You *must* update community agency information annually**. It is best to make a personal visit or phone contact with the agency and review the information for any changes, and decrease or increase in services. Is there a *waiting list*? How long?

4. List the campus resources, such as tutoring programs, child care opportunities, on-campus support groups, Special Education programs, Job Retraining, and extended school day programs. **Include the phone number and a personal contact name**.

5. Develop a list of emergency **Hot Line** phone numbers.

6. As a counselor when you provide the client with specific referral to a community agency, it is practical to make a telephone contact **as the counselor while the client is there. In some cases**, it may be expedient for the client to speak with the Agency contact while with the counselor.

7. Develop a referral form clients can carry with them to the first appointment meeting at the agency. **Put the duplicate copy** and the **signed release of information form in the student file**. This form will permit you as the counselor to interface with the agency.

8. Keep a list of the client names and the date when they were referred to a community agency. Periodically review the list for updates.

9. _____

SELECTED RESOURCES: CRISIS/LOSS

CALIFORNIA ASSOCIATION for COUNSELING and DEVELOPMENT
Professional Development Committee
12/95

1. **AARP – American Association of Retired Persons**
   Social Outreach and Support Section
   601 E Street, NW; Washington, DC 20049
   Phone: (202) 434-2263 FAX: (202) 434-6474
   Publications

Bibliography on Grief and Loss	P. F. 1469 (893)	D435
Customs of Bereavement	P.F. 44591 (1090)	D14110
Celebrating Diversity	P.F. 4590 (1091)	D14078

2. **American Red Cross**
   Contact local office.
   Publications

After the Quake	Children's coloring book	ARC 2201	2/94
Disaster Preparedness	A coloring book	ARC 2200	1/94

3. **California Association for Counseling and Development**
   Professional Development Committee
   2555 East Chapman Ave. – Suite 201, Fullerton, CA 92831
   Phone: (714) 871-6460 FAX: (714) 871-5132
   Publication
   Caution: Crisis Ahead Counseling Skills Workshop and Manual

4. **California County Superintendents Educational Services**
   Contact local California County Education Officers
   Publication
   From Chaos to Control: School Crisis Response

5. **Centering Corporation**
   1531 North Saddle Creek Rd., Omaha, NE 68104
   Phone: (402) 553-1200 FAX (402) 553-0507
   Publication
   Request catalog, *Creative Caring Resources*

6. **Channing L. Bete Co., Inc.**
   200 State Road, South Deerfield, MA 01373-0200
   Phone: (800) 628-7733 FAX (800) 499-6464
   Publication
   Scriptographic Booklets

SELECTED RESOURCES for CRISIS/LOSS: continued

7. **Gilliland, Burl and James, Richard**
   Crisis Intervention Strategies. Pacific Grove, CA, Brooks/Cole Publishing Co.

8. **Los Angeles County Department of Mental Health**
   2415 West 6th Street, Los Angeles, CA 90057
   Publication
   Project Rebound Helping Children After a Disaster

9. **Los Angeles Unified School District**
   450 Grand Ave., Los Angeles, CA 90012
   Phone: (213) 625-6000 FAX: (213) 742-8195
   Publication
   A Handbook for Crisis Intervention

10. **Mental Health Association of Greater San Antonio**
    United Way of San Antonio and Baxter County, Texas
    Phone: (512) 341-5131

11. **Peterson, Suni and Straub, Ron.** *School Crisis Survival Guide,* West Nyack, NY Center for Applied Research in Education. 1992.

12. **Slaikeu, Karl A.** *Crisis Intervention: A Handbook for Practice and Research,* Boston, MA, Allyn & Bacon Inc. 1984.

13. **Southwest Regional Laboratory (SWRL)**
    4665 Lampson Ave., Los Alamitos, CA 90720
    Phone: (310) 598-7661
    Publication
    Preventing Chaos in Times of Crisis

14. **TAG – Teen Age Grief, Inc.**
    Linda Cunningham, Founder
    P O Box 220034, Newhall, CA 91322-0034
    Phone: (8805) 253-1932
    Publication
    Teen Age Grief: A Training Manual for Teen Grief Support

15. **Active Parenting Publishing**
    801 Franklin Court – Suite B, Marrieta, GA 30067
    Publication
    Helping and Healing Thru Loss A video-based program related to grief and loss

CALIFORNIA ASSOCIATION for COUNSELING and DEVELOPMENT

Professional Development Committee

SELECTED RESOURCES: DIVERSITY

Sexual Orientation

1. Bernstein, Robert. *Straight Parents, Gay Children.* Thunder's Mouth Press, New York, NY: 1995.

2. Besner, Hilda and Spungin, Charlotte. *Gay and Lesbian Students: Understanding Their Needs.* Taylor and Francis, Bristol, PA: 1995.

3. Brans, Jo. *Mother, I Have Something to Tell You.* NAL Penguin Inc.; New American Library, New York, NY: 1988.

4. DeCrescenzo, Teresa, Editor. *Helping Gay and Lesbian Youth: New Policies, New Programs, New Practice.* Harrington Park Press; Imprint of Haworth Press, New York, NY. 1994.

5. Due, Linnea. *Joining the Tribe.* Doubleday, Dell Publishing Group, New York, NY: 1995.

6. Fairchild, Betty and Hayward. *Now That You Know.* Harvest Book, Harcourt, Brace, Jovanovich, San Diego, CA: 1979, R1989.

7. Ferrante, Tony and Jacobson, Paulette. *Letters From the Closet.* Tzedakah Publications, Sacramento, CA: 1994.

8. Hasbany, Richard. *Homosexuality and Religion.* Harrington Park Press, New York, NY: 1989.

9. Marcus, Eric. *Is It a Choice?* Harper, San Francisco, CA: 1993.

10. Scanzoni, Letha Dawson and Mollenkott, Virginia Ramey. *Is the Homosexual My Neighbor? A Positive Christian Response.* Harper, San Francisco, CA: 1978, R1994.

11. Wishik, Heather and Pierce, Carol. *Sexual Orientation and Identity.* New Dynamic Publications, Lanconia, NH: 1995.

The **National Education Association** developed a training course to help teacher and adults talk about homosexuality.

Parents and Friends of Lesbian and Gays (PFLAG), 1101 14th St. NW – Suite 1030, Washington, DC 20005 (202) 638-4200

PFLAG, Long Beach, (310) 984-8335

CALIFORNIA ASSOCIATION for COUNSELING and DEVELOPMENT

Professional Development Committee

SELECTED RESOURCES: DIVERSITY

Multicultural

1. Bacon, Carrie L. *Celebrating Diversity: A Learning Tool for Working With People of Different Cultures.* American Association of Retired Persons, Washington, DC: 1990.
2. Behring, Shari T., Gelinas, Rosemary T., Munoz, Ana and Peyton, and Tracy. *Multicultural Consultation Training Manual.* California State University, Northridge, CA: 1995.
3. Morganette, Rosemary S. *Skills for Living: Group Counseling Activities for Elementary Students.* Research Press, Champaign, IL: 1994.
4. Pederson, Paul. *A Handbook for Developing Multicultural Awareness.* The American Association for Counseling and Development, Alexandria, VA: 1988.
5. Pederson, Paul, and Carey, John C., Editors. *Multicultural Counseling in School: A Practical Handbook.* Allyn & Bacon, Boston, MA 1994.
6. Sedlacek, W. E., and Brooks, G. C. *Racism in American Education: A Model for Change.* Nelson-Hall, Chicago, IL 1972.
7. Sue, D. W. and Sue, D. *Counseling the Culturally Different: Theory and Practice.* Wiley and Sons, New York, NY: 1990.
8. Wittmer, J. *Valuing Diversity and Similarity: Bridging the Gay Through Interpersonal Skills.* Educational Media Corp., Minneapolis, MN: 1992.

Agencies: Contact Local or District Office

Multicultural Education: Division of Curriculum & Instruction
Los Angeles County Office of Education
Downey, CA (310) 922-6323

National Conference of Christians and Jews
Human Relations/Interfaith/Intercultural Programs
Long Beach, CA (310) 433-8676

United Way of Greater Los Angeles
Directory of Health & Human Services Organizations
Long Beach, CA (310) 988-2500

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

ERIC

REPRODUCTION RELEASE

(Specific Document)

I. DOCUMENT IDENTIFICATION:

Title: Caution: Crisis Ahead. A Crisis Counseling Handbook.	
Author(s):	
Corporate Source: California Association for Counseling & Development	Publication Date: 1996

II. REPRODUCTION RELEASE:

In order to disseminate as widely as possible timely and significant materials of interest to the educational community, documents announced in the monthly abstract journal of the ERIC system, *Resources in Education* (RIE), are usually made available to users in microfiche, reproduced paper copy, and electronic media, and sold through the ERIC Document Reproduction Service (EDRS). Credit is given to the source of each document, and, if reproduction release is granted, one of the following notices is affixed to each document.

If permission is granted to reproduce and disseminate the identified documents, please CHECK ONE of the following three options and sign at the bottom of the page.

The sample sticker shown below will be affixed to all Level 1 documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

_____

_____

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

1

Level 1 ☐

Check here for Level 1 release, permitting reproduction and dissemination in microfiche or other ERIC archival media (e.g., electronic) *and* paper copy.

The sample sticker shown below will be affixed to all Level 2A documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE, AND IN ELECTRONIC MEDIA FOR ERIC COLLECTION SUBSCRIBERS ONLY, HAS BEEN GRANTED BY

_____

_____

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

2A

Level 2A ☐

Check here for Level 2A release, permitting reproduction and dissemination in microfiche and in electronic media for ERIC archival collection subscribers only

The sample sticker shown below will be affixed to all Level 2B documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

_____

_____

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

2B

Level 2B ☒

Check here for Level 2B release, permitting reproduction and dissemination in microfiche only

Documents will be processed as indicated provided reproduction quality permits.
If permission to reproduce is granted, but no box is checked, documents will be processed at Level 1.

I hereby grant to the Educational Resources Information Center (ERIC) nonexclusive permission to reproduce and disseminate these documents as indicated above. Reproduction from the ERIC microfiche or electronic media by persons other than ERIC employees and its system contractors requires permission from the copyright holder. Exception is made for non-profit reproduction by libraries and other service agencies to satisfy information needs of educators in response to discrete inquiries.

Sign here, please

Signature: Winifred Strong	Printed Name/Position/Title: WINIFRED STRONG - INTERIM EXECUTIVE DIRECTOR
Organization/Address: California Association for Counseling & Development 2555 East Chapman Avenue, Suite 720 Fullerton, CA 92831	Telephone: 714-87106460 FAX: 714-871-5132
	E-Mail Address: CALD@CALD.ORG Date: 11-26-2003